FINDING A WAY HOME

Delaware's Money Follows the Person Operational Protocol

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Money Follows the Person Steering Committee

Table of Contents

I. Required Contents of the Operational Protocol

A. Project Update/Project Introduction

Delaware requested an amendment to the 1115 Waiver to include the MFP population, the Elderly and disabled Waiver and the AIDS HIV Waiver. These waivers terminated 3/31/2012. The services of the 1915 C waiver and MFP services are included in the 1115 benefit package under Diamond State Health Plan Plus (DSHP Plus) services. There are state employed transition coordinators whose responsibility is to work with the DD population and in some cases the MH population . The contracting MCO's will provide transition services to all MFP participants who are eligible for DSHP Plus benefit package. The funding sources for MFP and 1115 budget will be clearly delineated. The 1115 waiver offers the services of the 1915 C waivers that terminated on 3/31/2012. The 1115 waiver was approved by CMS effective 4/1/2012. There is continuity of services for the waiver participants. The MCOs are providing services to those participants who are eligible for the 1115 benefit. MFP services are part of the Long Term Care DSHP Plus benefit package. The DD 1915 C Waiver was not incorporated in the 1115 Waiver.

In May 2007 the Centers for Medicare and Medicaid Services awarded Delaware a grant through the Money Follows the Person (MFP) Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. The State used MFP funding to enhance existing efforts to transform the long-term support system that serves people with disabilities and the chronically ill populations. MFP funding assisted in promoting the use of person-centered planning and consumer direction, and resulted in an increased use of home and community-based, rather than institutional services.

After receiving the MFP Rebalancing grant in May 2007, the Commission's MFP subcommittee began work to develop the program's operating procedures and identify and address barriers standing in the way of the program's success. It now serves as the MFP Steering Committee. The Commission on Community-Based Alternatives for Persons with Disabilities remains responsible for overarching oversight of Delaware's MFP program.

Delaware titled its MFP program ***Finding A Way Home***. This amended protocol outlines the major steps and processes that support the successful transition of individuals from institutional to community settings. These steps are discussed in detail within this protocol, beginning with Delaware's assurances that it will meet the four key demonstration objectives as outlined in statute.

Delaware's ***Finding A Way Home*** program's mission is to compliment Home and Community Based Services (HCBS) with MFP demonstration services to assist participants to transition back into the community. The enhanced MFP funds will fund the services of State Employed Transition Coordinators and Nursing staff who will identify barriers and implement plans to overcome obstacles and improve community based services. These Coordinators develop relationships with residents, families and facility staff to facilitate communication and to develop solutions to individual barriers to transition. The contracting MCO are responsible for providing services to participants eligible for 1115 waiver as described in the DHSP Plus benefit package and those who also meet MFP protocol eligibility requirements. As part of the MCO contract , MCO's are responsible for providing all services for which the member is eligible. This includes those individuals who are eligible for MFP services. The transition team which includes MCO's, facility

staff, community based staff, family, friends and any other person the member chooses work together to develop a transition and back -up plan for a safe, secure and medically/socially adequate plan for community living.

MFP funds provide transitioning individuals with intensive supportive services such as self-directed Personal Assistant Services and Assistive Technology. The ***Finding A Way Home*** Project Director tracks the data collected from the MFP demonstration, which is used as a basis to enhance the existing HCB Waiver services to better support individuals in the community. This information is shared with the Commission on Community-Based Alternatives for Persons with Disabilities and its MFP Steering Committee. The Project Director also receives reports from the contracting MCO to track the data collected from the MFP demonstration services. The Commission promotes long term and sustainable system changes by advocating for the funding and/or policy changes required to fill the gaps in the service delivery system with appropriate State legislative and governmental agencies, advocacy groups, and provider groups. The MCO's will also assist the State in conducting outreach regarding the MFP program.

1. Key Demonstration Objectives

1.1 Increase in Use of Home and Community-Based Services

Delaware has worked closely with stakeholders in its efforts to rebalance its long-term care support programs and expand its home and community based alternatives to meet the needs of individuals who want to remain in their communities. .

In order to assist individuals with disabilities to achieve maximum independence, DMMA obtained the state funds needed in state fiscal year 2008 to develop a Medicaid Buy-In (MBI) program. MBI will offer disabled individuals an incentive to pursue employment and increase their earnings without fear of losing essential health care coverage. Program recipients will buy-in to Medicaid by paying a monthly premium based on their income.

With the ***Finding A Way Home*** program, Delaware plans to transition a total of 100 individuals from multiple target populations from institutional to community-based homes over the first four years of the demonstration project. An addition 131 individuals will be transitioned through 2016. The individuals slated to receive services will transition from Delaware's public long-term care institutions, which will include: the Delaware Hospital for the Chronically Ill, Emily P. Bissell Hospital, and Governor Bacon Center, the Stockley Center and the Delaware Psychiatric Center. In addition, individuals transition from private nursing facilities and Delaware's one private ICF/DD The Mary Campbell Center.

Finding A Way Home relies on a variety of home and community-based services and supports to transition qualified individuals. Once the transition period has concluded, transitioned individuals are able to maintain themselves in a community setting through services available under the State's 1115 Waiver, the 1915 C DD Waiver, the Medicaid State Plan, the Social Services Block Grant, the Older Americans Act, and community-funded programs.

DMMA works together with the DSHP Plus CM to set up home and community based services for those individuals wishing to transition from the facility to community

State employed MFP staff take a similar approach to person with mental health issues and persons with cognitive/developmental disabilities, working closely with DSAMH providing state plan services and DDDS, which operates the DD HCBS Waiver. Individuals living in ICF/DDs who wish to transition to the community are identified through annual person centered planning meetings and provided all assistance needed to implement the transition. The State addresses the needs of individuals wishing to transition from the Delaware Psychiatric Center, Delaware's ICF/IMD facility, as part of this MFP demonstration. The State is currently collaboratively working with all the Divisions responsible for providing care for these individuals in the institutional setting.

1.2 Eliminate barriers that prevent individuals currently residing in state or private facilities from accessing needed long-term community support services

Delaware's strategies to eliminate barriers include the following:

- MFP staff will increase the level of outreach they provide to institutionalized individuals. This will result in increased awareness about home and community options for individuals living in facilities.

  Barriers encountered under the DSAAPD Nursing Home Transition Program DPIP included lack of affordable housing, drug or alcohol use and lack of family and other informal support network. DPIP also found that many facility residents have a "learned dependency" that makes it difficult for them to follow through on their decisions and make arrangements on their own.

  The CILs conduct ***On Your Own*** workshops available to all MFP participants or interested participants. . An overview of these workshops can be found in Appendix K. The Marketing and Outreach Coordinator also provides an overview of the ***Finding A Way Home*** program and provide attendees (both facility staff and residents) with informational material regarding this program. This material includes information regarding how to make a referral to the Finding A Way Home Project Manager or to Delaware's Aging and Disability Resource Center (ADRC) to be assessed for the program. The ADRC also serves as Delaware's Local Contact Agency (LCA) for referrals from the nursing facilities that are generated from Section Q of the MDS 3.0. The ADRC is located within the Division of Services for Aging & Adults with Physical Disabilities (DSAAPD).,

- Potential program participants access the services of a Transition Coordinator, who will work closely with them and their transition team to assess all their needs and create a comprehensive transition plan. Transition Coordinators provide the intensive assistance institutionalized individuals need in order to access the community based services needed to support them safely in the community. They assist them locating affordable housing and access needed supportive services, including AA or Al Anon as appropriate. Program participants choosing to access the DD Waiver or MH state plan services will be assisted by State staff.

The program makes MFP demonstration services available to ease the transition back into community living. Some of these are one-time occurrences, such as home adaptations or security

deposits. Others, such as the self-directed personal assistance service, are designed to afford consumers, their authorized representatives, and their case manager maximum flexibility.

Transition Coordinators identify reasons why individuals to whom they are assigned are unable to leave facilities (i.e., unable to meet Medicaid financial eligibility criteria in community, guardian refuses permission to transition, needs cannot be met with current service array, etc). The Transition Coordinators report this information in their monthly status reports to the MFP Project Director. The Project Director tracks these reasons and will present this information to the MFP Steering Committee, which will identify methods to address such obstacles.

Demonstration services are made available to ease the transition back into community living for all population groups being served by the grant. Some of these services are for one-time occurrences, such as security deposits, home furnishings, assistive technology, and home modifications. Other services, such as Personal Assistance services and Transition Coordinator services, are provided throughout the participant's stay in the project to further ease their transition. The availability of flexible funding has been shown to make a significant difference in enabling de-institutionalized individuals achieve their goal of living in the community.

Program participants who choose to utilize the MFP demonstration personal assistance service will have the following options once their 12 months on the demonstration comes to an end:

- **Finding A Way Home** program participants can access the Personal Care Waiver service once their year on the Finding A Way Home program ends. In addition, DSAAPD has a state-funded Attendant Care program that *Finding A Way Home* program participants may access at the end of their demonstration period.

- **Finding A Way Home** program participants who are in the DDDS Waiver program and those transitioning from DPC can access the Medicaid State Plan service of Personal Care services. However, this service does not currently offer users with ability to self-direct this service.

The MFP Steering Committee and the larger Governor's Commission on Community-Based Alternatives for Persons with Disabilities are vital to the success of the Money Follows the Person Rebalancing demonstration initiative and in creating long term sustainable system change. They provide ongoing oversight and advice on State policy changes to achieve rebalancing, monitor grant implementation progress, monitor achievement of grant benchmarks, and to suggest ways to improve program design or implementation. They will continue work to improve the flexible use of Medicaid funds to support consumer preferences for home and community based care with the goal of preventing unnecessary or premature institutionalizations and to allow consumers a wider range of options.

1.3 Improve the ability of the Delaware Medicaid Program to continue the provision of HCB LTC services to individuals choosing to transition to communities

Delaware assures the continuity of services to MFP participants following their one-year transition period to community living. Participants are enrolled in the 1115 Waiver program as of the first day of their transition to the community or the 1915 C DD Waiver for the DD population or Medicaid State funded services for the mental health population . They receive home and community based services and supports through the 1115 Waiver program, the Medicaid State Plan, and other programs for which they may qualify. Participants are assigned a MFP Transition Coordinator who is responsible for coordinating all aspects of a participant's care plan, as well as monitoring the provision of services provided under that plan. Participants are also be assigned to a case manager, who works closely with the Transition Coordinator and authorize all waiver services chosen by the participant. The case manager will continue to monitor the plan after the participant's year in the MFP program comes to an end. The case manager and nurses are part of the MCO's staff and work with the team to develop a transition plan to meet the needs of the member. As part of the MCO's contract, the MCOs hired transition coordinator staff to assist in the smooth transition of the MFP LTC population. The MCO team consists of RN's, CM, Transition Coordinators, Behavioral Health Staff (when applicable), and consultation with the MCO Medical Director (when applicable) to develop plans of care for community living.

The MFP program's ability to use funding flexibly within program guidelines is critical to prevent unnecessary or premature institutionalizations and allow participants a wider range of options. Delaware gathers data on consumer satisfaction and positive outcomes to support future budget requests for continued/increased funding of HCB services. Delaware moved to an integrated long term care arrangement, by amending its existing 1115 Waiver program to include the long term care population. All HCB services offered under Delaware's current 1915c Waiver programs are incorporated into any integrated long term care waiver arrangement and additional services may be added as well. . The use of these tools, particularly within the context of self-directed service planning and delivery philosophy that Delaware has embraced, will advance the national objective of the MFP Demonstration.

1.4 Ensure procedures are in place to provide continuous quality improvement in long term care services

Delaware developed each of the required ten components of MFP with the focus on the program participant and how the participant interacts with the program. Our intent is to make this process as receptive to participants and their needs to the maximum extent possible. This will ensure that we are successful in creating a dynamic and enduring community-based system of long term supports so that all Delaware citizens may live and age with respect, dignity, choice and control.

MFP is administered in parallel with the 1115 Waiver and the 1915C DD Waiver, the quality assurance protocols developed for each of the Waivers will be the basis for the required quality assurance strategy, which is outlined in section 8 in more detail. In addition, all demonstration participants will have the opportunity to participate in face-to-face quality of life surveys. MFP staff will also administer a consumer satisfaction survey (see Appendix Q). The results of these surveys will be shared with the MFP Steering Committee to relay the experiences of the participants and to develop intervention strategies to assist in program improvement activities. The MFP Steering Committee will analyze all negative outcomes and develop corrective action plans that address these outcomes. These action plans will be shared with the state agencies that

operate the HCB DD Waiver program and the 1115 Waiver and the Governor's Commission on Community Based Alternatives for Persons with Disabilities. These entities will utilize this data on consumer satisfaction and positive as well as negative outcomes to support future budget requests for continued/increased funding of HCB services.

Transition Coordinators will monitor program recipients closely for their first year in the community. Coordinators will visit the recipient at least twice a week for the first month in the community to assure that services are being delivered timely and appropriately. Coordinators will conduct home visits at least weekly in the second month and every other week in the third month. Once the program recipient is comfortable that services are stable, the Transition Coordinator will begin making monthly visits. These visits will continue through the first year in the community.

1115 Waiver Case Managers and Nurses will have primary responsibility for the participant's care plan and will assure that services continue without interruption once the MFP period ends. The transition process will be seamless to the individual. Case Managers and Nurses will follow the same schedule for contact under the 1115 waiver requirements, . The care plans are updated at least annually unless updated sooner as a result of medical needs changing i.e. post hospitalization.

DMMA contract and program staff monitors the contract and provides quality management oversight from day one of implementation. In addition to this oversight, an EQRO consultant conducts a review to ensure not only MFP requirements are followed but that the DSHP and DSHP Plus requirements are adhered to by the MCOs

The following entities also contribute to MFP's quality improvement strategy:

Licensure and Certification

The Division of Long Term Care Resident Protection (DLTCRP) is responsible for the licensure and/or certification of neighborhood group homes as applicable under Delaware Code Title 16 Subchapter IV Part II Chapter 11. Surveyors monitor the performance of these providers by conducting routine surveys, inspections and complaint/incident investigations and require a corrective action plan if state violations and federal deficiencies are found. Follow-up surveys and inspections are conducted to ensure that the provider has effectively implemented any required corrective action plan. All surveys and inspections are unannounced and include an observation of the care of the individual.

The Division of Public Health (DPH) is responsible for the licensure and/or certification of home health agencies and adult day care facilities. Adult day care facilities must meet all licensure requirements under ADC 16 Delaware Code I (1), II, 122 (3) sl. Adult day care facilities must have an RN or LPN on duty at all times. Home health agencies must meet license requirements under Home Health, 16 Delaware Code, 122(3) n and are required to make services available 24 hours a day, seven days per week. DPH staff monitors the performance of these providers by conducting inspections and complaint/incident investigations and require a corrective action plan if state violations and federal deficiencies are found. Follow-up inspections are conducted to ensure that the provider has effectively implemented any required corrective action plan.

Contract Monitoring

Each Division (, DMMA, DDDS, and DSAMH) and Contracting MCOs monitors the service contracts it holds. This may include conducting random, on-site contract monitoring visits to ensure providers are in compliance with program rules and to verify service delivery and payment.

The Management Services Section of DMMA is responsible for several distinct functions, which support the work of the Division. This section provides tracking of services, forecasts budget, and insures that our bills are paid along with many other items. The Accounting Unit within this section is responsible for managing the administrative expenditures, contracting, and assuring compliance with State Accounting rules. The Reimbursement Unit is responsible for setting rates to pay direct client service providers and for forecasting expenditures and budget needs for services to clients. The unit is also responsible for monitoring and reporting current expenditures and trends for all of our programs.

Customer Relations Unit (CRU)

DMMA shares a Customer Relations Unit (CRU) with the Division of Social Services. The CRU receives complaints from applicants, Medicaid recipients, and/or their families and representatives. Staff from the CRU unit investigates the complaint and follows it through resolution unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Adult Protective Services office, the agency with statutory responsibility for the investigation of such allegations. Resolution of complaints not referred to APS are tracked and recorded in the CRU Complaint Data Base.

Adult Protective Services (APS)

APS is responsible for investigating allegations of abuse, neglect, and exploitation of adults who are elderly or those with disabilities, including cases in which a provider is alleged to have abused, neglected or exploited a participant. APS assigns priority levels to complaints at the time of complaint intake. The investigator may change the priority level as a result of information obtained after contact is made. APS makes contact within 24 hours in cases of physical abuse or extreme neglect, or abandonment. This contact is face to face. All other cases, contact is made within 5 working days.

Once an investigation is complete, the abuse will either be substantiated or unsubstantiated. The burden of proof is "reasonable cause"....which is a lower standard than "preponderance of evidence". If the abuse or neglect is severe that it crosses over into criminality, then APS forwards the case onto the Attorney General's office for prosecution. If the abuse or neglect is a matter of lack of education or resources, (and unintentional), APS puts the necessary services in place, educates the family and develops a case plan, monitors, then eventually closes the case. Before the case is closed, APS always make final contact with the reporting individual regarding its findings.

DSAAPD has a TTD statewide phone number for the hearing impaired. APS follows up on a report the same way it was reported to APS (i.e. e-mail, letter, phone call from a 3rd party, etc.). APS'

experience is that individuals that have cognitive difficulties generally make a referral to APS with the assistance of a trusted person. APS also indicates that it is rare that victims report their own abuse. Often health care professionals, neighbors, friends or relatives make the report. Bank personnel are trained to recognize patterns of unusually activities in an individual's account and will report their suspicions of financial exploitation to APS. Often financial abuse goes hand in hand with other forms of abuse.

3. Benchmarks

Benchmark #1: The number of eligible individuals in each target group who transition.
The following table represents the projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence during each year of the demonstration.

Grant Year	Elderly	Individuals with intellectual Disabilities	Physically Disabled	Mental Health Issues	TOTAL
CY 2008	**1**	**1**	**1**	**0**	**3**
CY 2009	**5**	**0**	**12**	**2**	**19**
CY 2010	**7**	**1**	**6**	**0**	**14**
CY 2011	**7**	**1**	**12**	**0**	**20**
CY 2012	**8**	**2**	**14**	**1**	**25**
CY 2013	**10**	**2**	**17**	**1**	**30**
CY 2014	**12**	**2**	**20**	**1**	**35**
CY 2015	**13**	**3**	**23**	**1**	**40**
CY 2016	**16**	**3**	**25**	**1**	**45**
TOTAL	**79**	**15**	**130**	**7**	**231**

Note: For those with mental illness deinstitutionalized from The Delaware Psychiatric Hospital, only individuals as 65 and older will be considered for the ***Finding A Way Home*** program.

Benchmark # 2: The annual percentage increases each year for the total cost of in the HCBS programs.

This benchmark addresses the anticipated increase in HCBS participation overall. The services provided in the E& D waiver will be incorporated in the amended 1115 Waiver to cover the LTC population under DSHP Plus services.
The MFP project will support Delaware's work to expand the number of people served in the community instead of in institutional settings. The following table represents the expenditures for HCBS for all individuals. The MR, E&D & AL Waiver HCBS service amounts for SFY 2011 forward are based on trends observed during State Fiscal Year 2008-2010 Medicaid expenditure data and were trended forward through SFY2016

SFY11 -SFY16: For MR inflated by 4% each year; For ED inflated by 12% each year; For AL inflated by 23% each year; For MWP inflated by pmpy average waiver co

Benchmark # 3:
Of the individuals who transition out of facilities as MFP participants, no more than 5% will revert back to institutional care within 1 year of the transition.

Grant Year	MFP Participants	Institutional Readmissions
CY 2008	**3**	**0**
CY 2009	**19**	**2**
CY 2010	**14**	**0**
CY 2011	**20**	**1**
CY 2012	**25**	**1**
CY 2013	**30**	**2**
CY 2014	**35**	**2**
CY 2015	**40**	**2**
CY 2016	**45**	**2**
TOTAL	**231**	**12**

Benchmark #4: Number of individuals self-directing a portion of their HCBS.

A person-centered system respects and responds to individual needs, goals and values. Within a person centered system, individuals and providers work in concert to guarantee the individual's values, experiences and knowledge drive the creation of an individualized plan of care as well as the delivery of services.

Self-direction gives the individual the freedom to choose where and with whom they live as well as how they organize all important aspects of their life with freely chosen assistance as needed. It gives the individual the ability to choose the manner in which they are supported. It also gives the individual the ability to decide how money available for support services will be spent. With self direction comes the responsibility to make responsible choices and make the effort to have positive relationships with friends, family, and neighbors.

DDDS moved from deficit-based service planning to strengths-based person-centered planning (Essential Lifestyle Planning). ELP was implemented with fewer than 40 individuals in 1999 and is now used with all DDDS consumers.
The state anticipated that, through the implementation of the Money Follows the Person Demonstration and removal of barriers to self direct, that 33% of MFP participants will choose to self direct their care within the first full year of the demonstration. Further, the state anticipated this percentage would increase each year. In the final year of the demonstration, it is anticipated 95% of MFP participants will self direct their care.

MFP participants who will opt to self-direct their services

	MFP Participants	Number self-directing	Percentage
CY 08	3	1	33%
CY 09	19	15	79%
CY 10	14	12	86%
CY 11	20	18	90%
CY 12	25	23	92%
CY 13	30	28	93%
CY 14	35	33	94%
CY 15	40	38	95%
CY 16	45	43	95%
TOTAL	231	211	

Benchmark # 5: Number of individuals receiving assistance with finding and securing subsidized housing each year.

The State works with the Public Housing Authorities (PHA) to obtain commitments for housing units and housing vouchers for individuals who plan to transition from Delaware facilities. With the assistance of MFP, Delaware's United Cerebral Palsy organization obtained 12 Step-Up housing assistance vouchers that it designated for MFP recipients. The MFP Outreach and Housing Coordinator will attend PHA meetings throughout the state to explain MFP and how the PHA's can participate. The state will ask for commitments from the 5 PHA's to set aside a number of public housing units or vouchers for Finding A Way Home participants. MFP staff met with the largest PHA and has begun the discussion of possible set-asides. In addition, the state will monitor where housing is available in an effort to target outreach. The state continues to gather information regarding barriers to the affordable, accessible housing. The state will monitor any notices for funding availability (NOFAS) or housing opportunities that may come available and suitable to serve MFP or other disability populations

The Cabinet Secretary of the Department of Health and Social Services hosted a Housing Policy Academy for the MFP program in 2011. All PHAs and other key stakeholders were invited to participate in this all day event to discuss the housing issues confronted by MFP recipients and to identify action steps to address these issues. Some of the housing issues and action steps identified were : the availability of an interactive housing data base, the PHAs partnering with DHSS to form set asides for those individuals exiting institutions. Collaboration with non Profit housers to identify any available , affordable accessible integrated housing for people with disabilities, building ongoing relationships with PHAs, assisting and encouraging PHAs to apply for any available tenant based or project based vouchers that come available, forming a partnership with the State housing Authority and DHSS to obtain funding and obtaining State Rental Assistance Program (SCRAP) vouchers. The Transition Coordinators work with the housing counselors for those individuals who have challenges with getting their housing needs met.

The State MFP staff is actively involved in assisting MFP participants with securing vouchers and coordinates with the MCO transition staff to ensure their members are notified as well about voucher opportunities.

The Governor's Commission on Community Based Alternatives for Persons with Disabilities Housing Committee with the State Council for Persons with Disabilities partnered with the Delaware Housing Coalition and the Homeless Planning Council are gathering data to use in obtaining resources for housing options with particular emphasis on accessible housing for the disabled. This committee is working to develop proposals and policies to implement solutions. Some examples are to continue to build connections between affordable housing and disability service systems and to prioritize community based care by redirecting resources from institutional care to community based services and provide for housing needs.

Each year, the number of individuals who receive housing assistance will increase as the number of transitions increase.

The number of public housing units/vouchers obtained as set asides for individuals transitioning from institutions:

Grant Year:	MFP Recipients:
CY 2008	0
CY 2009	13
CY 2010	6
CY 2011	16
CY 2012	
CY 2013	
CY 2014	
CY 2015	
CY 2016	
TOTAL	

B. Demonstration Implementation Policies and Procedure

1. Participant Recruitment and Enrollment

All persons who are eligible for home and community based services and reside in an eligible institution are eligible to participate in the MFP demonstration. This includes participants eligible for the amended 1115 Waiver and DDDS Developmental Disabilities waiver. In addition, those individuals deinstitutionalized from Delaware's IMD, the Delaware Psychiatric Center, who are not eligible for HCBS Waiver services will be eligible to participate in the MFP demonstration and state funded mental health services. The MFP Demonstration will include the entire geographical area of the state.

Individuals who wish to transition from a nursing facility will be considered as a potential participant. All Medicaid enrolled nursing facilities in the state of Delaware may participate. All Delaware nursing facilities are required to notify the LCA of any resident who expresses an interest in returning to the community during the MDS assessment. The LCA will make referrals as appropriate to the MFP program. The Delaware Long Term Care Ombudsman will provide education on the MFP program during their visits to the facilities to nursing facility staff and individuals wishing to transition. In addition, DMMA's Reimbursement Nurses visit all Medicaid enrolled facilities quarterly to reassess Medicaid residents' reimbursement level. These DMMA staff will provide information on the MFP program to potential candidates and to residents who expresses a desire to return to the community. Contracting MCOs will also provide information on the MFP program to potential candidates and process accordingly. The MCOs are responsible for sending all potential MFP referrals to the State's MFP Director to assure the individual meets MFP criteria. The MFP Project Director notifies the MCO that the individual meets MFP criteria and the MCO staff proceed with the transition plan. When DMMA intake staff receive a referral from a nursing facility resident for its 1115 or 1915 C Waiver programs and community services, these staff will make a referral to the MFP Project Director. In calendar year 2011, the MFP program utilized its MFP/ADRC grant funds to conduct independent assessments of all of DHSS' public facility residents to determine which residents are interested in transitioning to the community.

Delaware has two ICFs/DD. One, the Stockley Center, is operated by the State in Georgetown located in Sussex County. The second, the Mary Campbell Center, is privately operated and is located in Wilmington in New Castle County. Individuals who wish to transition from these facilities will be considered as a potential participant. Individualized, person-centered plans are prepared at the ICFs/DD during the person centered planning meeting on an annual basis. At this time transition into the community is discussed. In addition, State MFP staff will assure residents and staff of the ICFs/DD are aware that an individual may be identified at any time for consideration for the MFP demonstration program.

Individuals who wish to transition from Delaware's IMD, the Delaware Psychiatric Center (DPC), will be considered as a potential participant. Once a resident is determined to be psychiatrically stable, DPC staff will begin to discuss plans for transitioning back into the community. Psychiatric stability is determined by the DPC treatment team with information from the consumer, consumer family/advocates and previous community providers, if any. The Transition Planning process involves the individual, the individual's family, friends or other representatives, the DPC treatment team including the treating physician, and the MFP transition coordinator. On the community side the transition process involves a case manager with the DSAMH Community Continuum of Care Program (CCCP), the community provider and their treatment team, including their treating physician, pastors, & neighbors, etc. In addition, this process includes the DSAMH Community Mental Health Director and the Director of the DSAMH Office of Consumer Affairs. Transitions may also include the following: additional community providers (e.g. Day Program staff, Vocational Rehabilitation specialists), medical specialists, peer advocates, etc.

The following are the procedures and processes the state will utilize to ensure potential participants have the information they need to make informative choices about their care.

1.1 Selection Process

To qualify for transition, individuals must be eligible for Medicaid and have resided in the facility for a minimum of three months. The MFP Project Director within DMMA has access to the DMMA client eligibility system and can confirm the Medicaid eligibility of all candidates. As applicable, the Transition Coordinator, MCO CM and facility social service staff will work in collaboration with the nearest DMMA long term care eligibility unit to assist all non-Medicaid recipients in applying for Medicaid.

The target region for this population is the entire state. Individuals expressing a desire and interest to transition out of a nursing facility will meet with the MFP Transition Coordinator and MCO CM staff. The MCO CM staff will complete an assessment, with input from the Transition Coordinator, to determine the medical support, personal care, and other supports available to the meet the individual's needs for transitioning to a qualified residence. The MCO Case Manager and Transition Coordinator will also discuss the information with the legal guardians of individuals and with families and friends if the individuals give permission to do so.

Transition Coordinators facilitate the process of identification through contact with qualified facilities, the Long Term Care Ombudsmen, the CILs and DMMA intake staff and ADRC staff. In addition, DMMA Reimbursement Nurses will notify the MFP Project Director of any potential candidate they see during their quarterly reimbursement level assessments at Medicaid enrolled nursing facilities. The Transition Coordinators will provide information to residents to ensure an understanding of the MFP Demonstration Grant project. This information will be provided both written and verbally. The information includes information regarding the project itself as well as support services available to maintain the individual within the community. Once a potential candidate for transition is identified and clearly wishes to transition to the community, the appropriate MCO staff or DMMA staff conducts a thorough assessment to confirm eligibility, collect more information about the person's desires, needs, current services, housing preferences, and available support resources in their home/target community. Assessment are conducted through a standardized process established by the DMMA intake staff or MCO staff , using the approved PAE tool. The assessment process does not vary by MCOs and other intake processes. The assessment process is the same. The PAE tool is used for medical determination and is used across MCOs for consistency.

1.2 Enrollment Process

Once a determination is made that a candidate is eligible for the transition program, desires it, and can be effectively served by it, a preliminary transition planning team will meet with the individual as soon as reasonably possible, but no later than 10 days from the date the assessment is complete. The team will initially include the following people – the Transition Coordinator, the facility's medical and social service staff, or DDDS Waiver Case Managers or MCO CM staff, the individual, the individual's advocate if applicable, the individual's legal representative/guardian if applicable, and whomever else the individual/legal representative wishes to be present. Using a self-directed planning process, initial goals are developed for the transition.

Following the initial meeting, representatives from other agencies that will be able to provide services to meet the individual's pre-, during, and post-transition needs will be brought on to the team. The expanded team will meet with the consumer as soon as possible, but no later than 10 days

after the first meeting. A detailed person-centered plan including a transition plan is required to be completed for each individual. Completed plans will address needs before, during, and after transition. Factors to be considered in the transition plan will include:

- medical issues, support needs and resources to meet the identified needs
- behavioral challenges and resources to address the needs including the development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

During the pre-transition period, candidates will be encouraged to participate in workshops designed to build the requisite skills for successfully living on one's own, helping to minimize the likelihood that a transitioned person may need to return to a long-term care facility. These workshops will be based on the "On My Own Workshops" developed by Independent Resources, Inc (IRI) (See Appendix K for an outline of the curriculum).

Anyone wishing to enroll in MFP has a transition coordinator who works with the participant from pre-discharge through discharge from the facility and throughout the 365 day timeframe of MFP enrollment. Both the Transition Coordinator and CM team work collaboratively to assure continuity of services once services are rendered. The MCO staff assigned to MFP participants has their responsibilities clearly defined and those responsibilities are defined in the MCO contract.

While MFP eligibility is being determined, the Transition Coordinator will be in close communication with the all pertinent parties to inform them of individuals who are actively seeking to transition, including details such as identified housing preference and estimated dates of transition. The Transition Coordinator is required to regularly notify the MFP Project Director on a monthly basis, and more frequently as needed, on the status of MFP applicants. Close communication and coordination is critical as the individual progresses through the process.

Before an individual is placed in the MFP program, the MFP Project Director must receive a copy of the individual's assessment and Person-Centered Transition Plan and must approve the plan in writing. The Project Director is responsible for validating that all MFP criteria (qualified institution, duration of residency, Medicaid eligibility, qualified community residence, appropriate plan of care) have been met.

After an individual transitions to the community, he/she is regularly monitored for a period of no less than one year to ensure success of the transition. MFP Transition Coordinators will provide intensive transition coordination. The MFP Transition Coordinator will visit the individual in the community every two weeks for the first month, once each week for the second month, every two weeks in the third month and once a month thereafter – unless more frequent visits are required. The CM MCO staff will visit at least quarterly and assure all 1115 or 1915 C Waiver services are being provided appropriately. After the first year, the MCO CM or DD Waiver staff continue to monitor the status of each consumer.

Regular identification of any plan changes required due to the individual's needs, desires and progress will be considered during all phases of the transition process. The Transition Coordinator

and MCO or DD Waiver staff connect at least monthly in order to maintain close communication regarding the participant's status. All modifications to the plan are forwarded to the MFP Project Director or designee for approval and sign-off. Transition plans are developed in ways that are sensitive to and respectful of each individual's unique wants and desires, needs, characteristics, culture, and disability. Procedures outlined in the Quality Assurance section will be used to monitor individual safety and satisfaction during and after transition and to collect data that will be informative to Quality Improvement efforts.

The MCO or DD Waiver staff and MFP Project Director will be responsible for ensuring that the individual who will be participating in the MFP Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility.

Throughout the entire planning, transition, and post-transition process individual self-direction of services and budgets are a guiding value.

1.3 Reenrollment and Reinstitutionalization Policies

If a participant must return to an institution for more than 30 days prior to the completion of the 12 month demonstration period, the individual may re-enter the demonstration upon return to the community and participate for the unexpended duration of the demonstration period for that individual. If an individual must return to an institution for less than 30 days, they will continue to be participants in MFP while in the institution.

If a participant completes a twelve month period of the demonstration, and then returns to an inpatient status, future participation in the MFP grant will be determined on a case by case basis. Each case will be reviewed on an individual basis. Barriers will be identified that caused the first transition to be unsuccessful; a new transition plan will be developed that will address those barriers; and the current needs and wants of the individual will be considered. Each case will be monitored closely by MFP staff, MCO CM &DD Waiver staff within the respective state agency to assure their needs will be met at the time of discharge. Every effort will be made to allow the individual to return to and remain in the community. Arrangements may be made to secure the individuals place of residence on a case by case basis. The person's demonstration days will be cumulative over the grant demonstration period.

2. Informed Consent and Guardianship

2.1 Informed Consent Procedures

All individuals who wish to participate in the MFP Demonstration Grant project are asked to sign a consent form (see Appendix C) indicating they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents (see Appendix O). The critical incident reporting process outlines what constitutes a reportable critical incident (i.e. abuse, rights violation, medical errors). It also specifies who reports such incidents and to whom they make the report. Participants are also involved in the development of a back-up plan (see Appendix N) that serves to safeguard them against risks associated with moving to the community.

When, as a result of public awareness, marketing, outreach, and education activities described in the Operational Protocol, an individual is identified as a potential participant for ***Finding A Way Home***, that person is referred to the DMMA MFP Project Director. The Transition Coordinator will be responsible for obtaining informed consent from the individual or legally appointed guardian. The process of informed consent for the waivers will not change under the MFP demonstration. Transition Coordinators also carefully review the critical incident reporting process and their rights and responsibilities under the ***Finding A Way Home*** program (see Appendix P). In addition, the Transition Coordinator works with the participant and his/her transition team to develop an individualized back-up plan that safeguards the participant against risks and become a part of the plan of care. .

The age of majority in Delaware is eighteen (18) years. Prior to age 18, unless a child has achieved a status as delineated in the Delaware Code Title 13, Section 707, it is the parent or legal guardian of that child who acts on that child's behalf; i.e. giving informed consent. After the age of majority, every person is considered to be their own legal guardian unless adjudicated through the Court of Chancery to be incompetent and in need of a guardian (more information about Guardianship, see below).

Therefore, in Delaware the decision making power lies with each person, his/her legal guardian, or a Durable Power of Attorney for the person who chooses to be in the **"Finding a Way Home" Project**. The Transition Coordinator will assess the legal status of each applicant prior to gaining a signature of informed consent. The Coordinator will obtain a copy of the legal document(s), review it/them and have an understanding of the extent of the surrogate decision-making power that exists. This information can be garnered from a review of the facility records once consumer consent is obtained.

Each person will be provided all of the information that they will need to be able to make an informed decision about participation in the project and for each step thereafter. For participants with a guardian or other legal representative, both the participant and the legal guardian will be involved in providing information and the transition planning process. Should a person choose for others to be a part of these decisions, they have the option to invite them into the process; including family members, friends, etc. These same persons will be able to give feedback during the evaluative phase of this project, as well.

A fair and complete "Dignity of Risk" statement will be included in the information packets to provide awareness of risk and to allow for persons to choose the option they feel is right for them. This statement will explain that they have the right to make choices that others may support or see as dangerous or not appropriate and that they are also responsible for the consequences of that risk. The Transition Coordinator will review the statement with the consumer.

A definition of "informed consent" and of "confidentiality" will be included in the information shared with each participant so that they will understand the process. Each person will need to sign the Participation & Consent form to demonstrate written consent to participate in the project and to take part in the evaluation of the project. Finally, Delaware intends to include information regarding the participant's rights and responsibilities as part of the informed consent.

2.2 Guardianship

Delaware's Guardianship statute can be located in Title 12, Chapter 39, Sections 3901-3971 of the Delaware Code and for minors Title 10, Section 925(16). The Division of Medicaid and Medical Assistance (DMMA) under DHSS will adhere to Delaware state law in regards to legal guardianship in the ***FindingA Way Home*** program.

Delaware Code allows for the Court of Chancery and Family Court the power to appoint Guardianship of person or property or both of any disabled person resident of this State. If a potential participant has a legal guardian, that guardian has the authority to sign all consents on behalf of a person interested in being a participant in this project, but the person will always be an active member of the information sharing and decision making process for "***Finding A Way Home***." Facility Administrators are never appointed as legal guardians for their residents in Delaware.

As explained in the Court of Chancery of the State of Delaware's "Handbook For Guardians" (Revised 5/07), a "disabled person" means "any person who (1) by reason of being under the age of 18 is legally unable to manage his or her property or make decisions concerning the care of his or her person; or (2) by reason of mental or physical incapacity is unable to manage or care for his or her person or property or both."

3. Outreach, Marketing and Education

The MFP program hired a Marketing & Housing Coordinator to conduct outreach activities to Delaware facilities, PHAs and other stakeholders. Information and materials have been and continue to be developed specifically for Delaware's ***Finding A Way Home*** program. Outreach to facilities is individually designed appropriate to the culture of the particular facility based on input from nursing home ombudsman and Steering Committee members representing nursing facilities, DPC and. ***Finding A Way Home*** outreach material for nursing homes provides information regarding 1115 Waiver program including eligibility criteria and available 1915 C DD Waiver services. Outreach material for ICF/DDs provide information regarding 1915 C DD Waiver program. Outreach material for DPC provide information regarding DSAMH's Community Continuum of Care Program (CCCP) and State Plan services. The MCOs are also responsible for outreach efforts and were invited to and plan on attending the MFP Steering Committee as members . The MCOs are a direct information source for MFP information.

An initial letter from the Project Director with the ***Finding A Way Home*** brochure and related program information was mailed to each facility administrator at the time of the approval of the grant. The Marketing & Housing Coordinator conducted one-on-one personal contact to the facility administrators for the purpose of developing a collaborative relationship to determine how best to identify potential consumers within that facility. MFP Posters are visible to consumers and caregivers in the facility. All ***Finding A Way Home*** brochures and marketing materials continue to be reviewed by the MFP Marketing and Outreach subcommittee and the MFP Steering Committee for revisions, suggestions, and approval. The general and targeted audience brochures will be used to educate facility administration and staff, social service workers, discharge planners, families, and potential MFP consumers and providers. A general brochure developed for the consumer and public at large will include general introductory information and direction for the overall ***Finding A***

Way Home program. A copy of the general brochure is attached in Appendix J. Additional targeted audience materials will be developed as needed.

The targeted audiences are as follows:

Consumers
Consumer Family Members or Guardians
Service Providers
Hospital and facility-based Discharge Planners
Delaware Social Workers Association
Ombudsman and volunteers
LTC Facilities
Facility Resident Councils
Centers for Independent Living
Senior Centers
Public Health Agencies and Programs
Regulating Agencies
Healthcare Associations
Division of Medicaid and Medical Assistance (DMMA)
Division of Aging and Adults with Physical Disabilities (DSAAPD),
Division of Developmental Disabilities Services (DDDS)
MFP partners, other appropriate state agencies and non profits
State Service Centers
211 Staff
MCO Staff

3.1 Types of media to be used

In addition to the brochures for MFP information dissemination, information regarding the MFP ***Finding A Way Home*** project is available on the Commission on Community Based Alternatives for Persons with Disabilities website. Delaware has a statewide telephone "Helpline" which provides information, assistance and referral services for all Delaware citizens. Members of the MFP Steering Committee provided Helpline administrators with an overview of the MFP project. MFP training was given to all "Helpline" staff. In 2010, the Delaware Helpline implemented a "211" information line that operates after hours. An MFP training was given to the "211" staff.

Delaware's Aging and Disability Resource Center which is available through the Division of Services for Aging and Adults with Physical Disabilities offers a one stop access point for information and services to help Delawareans find the resources they need. This includes a call center with staff available to answer questions and provide information. It also includes a face to face , personalized options counseling / service enrollment opportunity . Contact the ADRC can be done through the toll free number at 1800-223-9074 or via email at Delaware ADRC@state.de.us

MFP staff provided an orientation on MFP to Family and Workplace Connections staff. This is a private social service agency for families and businesses, which operates the "ElderOnline" program. "ElderOnline" is a free elder care information and linkage service that helps older adults, caregivers and service providers connect older adults to services they need.
Family and Workplace Connections partners with AARP and other statewide agencies to provide information and assistance to older adults and people with disabilities.

Delaware's Division of Social Services (DSS) Customer Service Unit, which also supports DMMA, has been trained on MFP. The MFP program will exhibit or share targeted brochures with exhibitors at any local or statewide conferences and take advantage of free advertising in state and community newspapers, newsletters and public television stations through public service announcements (PSA's), which are being developed in conjunction with the DHSS Public Information Officer.

The MCOs are a source to dispense the MFP brochure and transition guide to their members as part of their marketing and outreach . The MCOs educate their members about MFP options as well as the member benefit package and community services.

3.2 Specific geographical areas to be targeted

The Marketing and Outreach Coordinator does presentations statewide. PSAs have been completed in 2011and will continue as needed.

3.3 Locations where such information will be disseminated

Informational materials are placed at all State Service Centers, Nursing Facilities, Independent Living Centers, Public Health Agencies, Senior Centers, Hospitals, DMMA eligibility offices, Long-Term Care facilities, Federally Qualified Health Centers, Doctor offices and Social Security Administration offices. These informational materials is placed in lobbies and other public areas in the above listed locations. ***Finding A Way Home*** outreach materials is mailed to targeted providers such as those named above. MFP and Ombudsman staff provide MFP outreach through personal contact and word of mouth as well as conduct workshops for facility residents and staff throughout the state.

The MFP Marketing & Housing Coordinator conducts ***Finding A Way Home*** informational sessions at facilities throughout the state. Facility residents, their families and facility staff are invited to these sessions.

3.4 Staff training schedules, schedules for State forums or seminars to educate the public

Delaware has two federally funded Centers for Independent Living (CIL), Independent Resources and the Freedom Center, with offices statewide. The ADRC works in collaboration with the MFP Marketing and Outreach Staff to educate the public on the MFP Project. DMMA utilizes the yearly Life conference to educate public about the program. .

3.5 Availability of bilingual materials/interpretation services and services for individuals with special needs

All of Delaware's MFP brochures are available in English and Spanish. Other culturally sensitive materials will be made available as needed based on state demographics and customer requests. Consumers are informed of agencies that can assist in cultural or literacy translation. All brochures are accessible according to federal standards to people with various disabilities. There is an

informational number sight impaired citizens can use to access the information on each of the brochures. A partnership will be formed with the Division of Visually Impaired for this purpose. The State is working towards accessible brochures and other information available on-line and by mail for disabled persons. MFP brochures and consumer information can be requested on the MFP website or by mail.

3.6 A description of how eligible individuals will be informed of cost sharing

The Waiver Case Managers are responsible for informing MFP and Waiver participants of all cost sharing requirements under the Waiver program. The Transition Coordinators inform and educate consumers about how the program will operate under the current MFP Demonstration Program.

Eligibility and cost sharing issues are addressed and discussed with the MFP consumers during the personal centered planning meeting. Individuals who are participating in the **Finding A Way Home** Program will be required to meet the current MFP and Medicaid eligibility requirements. In Delaware's MFP Demonstration Program, there will be no new eligibility requirement changes for consumers. Delaware Medicaid informs Waiver participants of their Medicaid eligibility and cost sharing in the initial letter sent to the participant notifying them of acceptance into the Medicaid Program.

4. Stakeholder Involvement

The Governor's Commission on Community Based Alternatives for Persons with Disabilities, (described in the Introduction section of this protocol) represents what is intended to be an enduring and overall guide for collaboration that brings all key MFP partners to the table and keeps them engaged, committed and informed. This is perhaps the most critical collaboration that will remain in place to ensure success of the overall MFP demonstration program and to foster enduring long term, systems change and transformation once the enhanced FMAP rate has ended. The comprehensive representation reflected in the planning and development of the MFP grant application reflects this emphasis on collaboration in creating enduring systems change. A component of effective collaboration is open communication about program progress and issues impacting or facilitating progress. As one formal means of open communication, the Project Director makes regular reports to the Governor's Commission and to the MFP Steering Committee. Reports will include details about program activities (e.g., services provided, number of people screened, assessed, transitioned, program and service expenditures, activities geared toward rebalancing and systems transformation) and program progress (e.g., individual outcomes, consumer satisfaction, effects of transformation and rebalancing efforts). Reports to the Governor's Commission will be publicly available. The Commission members are listed below:

Name	***Title***	***Organization***
Rita Landgraf	**Commission Co-Chair Cabinet Secretary**	Department of Health & Social Services
Dori Connor	State Representative	Delaware General Assembly
Dr. Michael Gamely-McCormick	Director	University of Delaware Center for Disabilities Studies

Andrea Guest	VR Division Director	Division of Vocational Rehabilitation
Larry Henderson	Executive Director	Independent Resources, Inc.
Margaret Rose Henry	State Senator	Delaware General Assembly
Kevin Huckshorn	Director	Division of Substance Abuse and Mental Health
Anas Ben Addi,	Director	Delaware State House Authority
Helene Keeley	State Representative	Delaware General Assembly
Stephen Kingberry	Executive Director	Delaware Transit Corporation
Jim Lafferty		Governor's Advisory Council on Substance Abuse & Mental Health
William Love	Director	Division of Services for Aging Adults and Physical Disabilities
Name	***Title***	***Organization***
Roy Lafontaine	Deputy Director	Division of Developmental Disabilities Services
Bill Adami	Chief Executive Officer	Easter Seals of Delaware and Maryland's Eastern Shore

As part of the MFP Demonstration, Delaware established a MFP Steering Committee for its ***Finding a Way Home*** Project. The Steering Committee membership is as follows:

Last Name	***First Name***	***Title***	***Organization***
Barlow	Thomas	Director Adult Day Program	Easter Seals
Brockenbrough	Kimberly	Planner	Delaware State Housing Authority
Allen	Carol	Director Community Health	Division of Services for Substance Abuse and Mental Health
Carter	Anthony		JEVS
Henderson	Larry	Executive Director	Independent Resources, Inc.

Hodges	Kyle	Executive Director	State Council for Persons with Disabilities
Kling	Nancy	HCCC, Waiver Adm.	DMMA
Ashby	Edwarda	MFP Project Director	DMMA
Anderson	Dee		DDDS
Unkyong	Goldie	Financial Analyst	DMMA
Lewis	Barbara	Policy Administrator	Division of Medicaid and Medical Assistance
Johnson	Nicole	Management Analyst	DMMA
Edwards	Dawn	Director of Social Services	Division of Public Health, Hospital for the Chronically Ill
Maichle	Patricia	Executive Director	DE Developmental Disabilities Council
McMullin-Powell	Daniese	Marketing & Outreach Coordinator	Division of Medicaid and Medical Assistance
Orija	Victor	Senior Social Service Administrator, Ombudsman	Division of Services for Aging & Adults with Physical Disabilities
Posey	Brian	Associate State Director	AARP
Swift	Lee	OBRA Administrator	Division of Developmental Disabilities Services
Spielcki	Jerry	Director	The Mary Campbell Center
Wolfe	Jamie	Consumer	
Wozny	Andrea	Nursing Home Transition Administrator	Division of Services for Aging and Adults with Physical Disabilities

Following approval of the Demonstration Grant, stakeholder involvement has increased with the development of the Money Follows the Person Rebalancing Demonstration Operational Protocol. Consumers, consumer and community advocacy organizations, institutional providers and other stakeholders continue to play a critical role in the implementation and ongoing activities associated with ***Finding A Way Home,*** as they did with the initial grant application. Additional consumer representation will be added to the Committee to assure representation across disabilities and geographic areas. At a minimum, the Committee will seek to add three consumer representatives – one discharged from a nursing home, one from an ICF/MF and one from DPC. In addition, at least two parents or other family members of consumers will be recruited. Additional advocates and provider agency representatives will be added as they are identified.

Committee meetings are open to the public and a conference call in line is always available. Therefore anyone who wishes to participate is able to contribute to the discussions. Since Delaware is small, participation by the general public is readily feasible. This ongoing process will result in lasting change that will be embraced by a full spectrum of providers, partners and stakeholders involved in ensuring the health and community inclusion of all individuals who are served through

Delaware programs. It will continue to serve as the platform for involving stakeholders in the Finding A Way Home Rebalancing Initiative.

The MFP Steering Committee monitors the MFP Demonstration throughout the grant cycle until its conclusion. It reviews progress and project status on at least a quarterly basis. Any needed reports on the status of the Demonstration and/or recommendations for program improvement and successful transition outcomes will be provided to DMMA and the State's Joint Finance Committee. The Steering Committee will also collaborate with the Department of Health and Social Services Advisory Councils on Aging and Adults with Physical Disabilities; Developmental Disabilities Services and Substance Abuse and Mental Health. These are all Governor's appointed councils that make recommendations related to the divisions' rules, policies and practices. In addition reports will be provided to the non-Governor appointed, State Council for Persons with Disabilities.

4.1 Consumer and Institutional Providers' Roles and Responsibilities

The purpose of the MFP Steering Committee is to provide input, decision making authority as the stakeholder body, and monitor implementation of the MFP Demonstration throughout the five-year period. Consumers and institutional providers provided significant guidance, advice and outcome measures to the Operational Protocol. They will continue to provide this guidance with the MFP Demonstration implementation and progress, and review the state in its obligation to meet its benchmark evaluative standards. In addition, the stakeholders will help the state in building consensus for sustainability of the MFP Demonstration after the grant cycle.

Consumers had decision making roles in the design, development and implementation of the Operational Protocol. They will continue to have a decision making role throughout the Demonstration, including being involved in the identification of those individuals who will be transitioned and assisting individuals during their transition out of institutions. The State will seek MFP demonstration participants to serve as members of the MFP Steering Committee. In addition, consumers with experience in transitioning and/or the waiver programs will be ideal candidates to act as peer mentors. This will provide an avenue for consumers to directly influence the process and better inform the MFP Steering Committee of transition challenges and successes.

Institutional providers also have an active role in the design and development of the operational protocol and be involved in the Demonstration in the transition context. Institutional providers are a part of a transition team, which will identify potential candidates for the MFP Demonstration project. Transition teams may include the resident considering transition and his/her preferred representatives, including family members if they so choose; appropriate institutional staff; consumers with experience in community settings and/or transitioning; appropriate State agencies and Centers for Independent Living. The discharge procedure will be one that incorporates self directed and person centered planning. The planning is specific to the needs of the individual, i.e. an individualized discharge plan.

Direct care staff at facilities will advise residents and inform nurses about elements of care that will be needed in the community. In addition, direct care staff may participate in trainings and be encouraged to pursue employment as community providers in order to continue supporting the individuals whom they serve as they move to a new setting if the consumer chooses such an option. Social workers at the facilities will be providing direct assistance to the residents in the transition

process by helping to secure needed documentation, such as prescriptions from doctors and copies of medical records, and will be helping to obtain durable medical equipment needed prior to and at the time of transitions. The cooperation of all staff working with residents at institutions will be required to facilitate a smooth transition and continuity of care between settings. Institutional administrators need to understand and support the MFP demonstration so they can assist in disseminating the information and encourage facility staff to fully participate in the process. The professional organizations that represent the staff at facilities may help support the project by allowing advertisements and articles about MFP in their newsletters and websites.

Social workers will also assist the transitioning resident with housing options. All types of housing preferred by the resident will be considered. (e.g. living with family, public or private housing, subsidized apartments). Community supports will also need to be evaluated and the resident will need to consider waiver transitioning services, demonstration services, Medicaid State Plan services, etc. which may benefit their transition into the community. Institutional providers will also work with the resident to locate outside physicians to follow the patient after discharge. Appointments may be scheduled with that new physician prior to discharge or the resident is scheduled within two weeks of the discharge date so all medications can be refilled in a timely manner. Other appropriate referrals are made such as home health aide services, Meals on Wheels, financial assistance, food stamps, DAST Paratransit, and other accessible transportation.

4.2 Operational Activities with Consumers and Institutional Providers

The MFP Steering Committee was established to include representation from various stakeholders including consumers and institutional providers. One of the functions of the Steering Committee is to collaborate & assist with the amendment of the *Operational Protocol*.

For ongoing input, the process continues to involve the MFP Committee as the stakeholder body with decision–making authority for this MFP grant. It has cross disability and it is focused on the improvement of home and community based services. The MFP Steering Committee will continually be involved in the planning, product development and decision-making with the MFP Rebalancing Demonstration. The Demonstration ensures stakeholders and consumers continue to be involved in the development and implementation of the demonstration project through public forums, meeting with existing advisory groups, and other ongoing written, electronic, and verbal communication mechanisms.

The Department of Health and Social Services recognizes the value of direct consumer opinion. Throughout the demonstration project, consumers have the opportunity to provide input through information gathering tools developed for use in the demonstration project and other forums for collecting information about the quality, appropriateness and efficiency of services. This information will strengthen the Money Follows Person demonstration, and assist the State with identifying areas of need for the ongoing development of a sustainable nursing facility transition program with the highest quality of options and services.

5. Benefits and Services

The delivery mechanism for the grant participants will be managed care and fee for service.

The Project Director works in collaboration with the MCOs, DDDS, DSAMH and on monitoring this process.. The state assures the process is seamless to the participant by having a slot available at the onset of participation. The services provided during the grant will continue to be provided once the one year period is over, with the exception of demonstration services used during the first year for housing related expenditures, home modifications, etc. as designated by the MFP guidelines. The chart below identifies the qualified HCBS Waiver programs for individuals participating in the MFP demonstration. An individual may only participate in one waiver at a given time, but may be moved from one waiver to another during the one year demonstration based on their needs.

Program Name	Administration	Overview
DD Waiver	Division of Developmental Disabilities Services	An array of specialized services, including residential services, are covered by Medicaid for participants who have MR/DD conditions
1115 DSPH Plus Waiver	Division of Medicaid and Medical Assistance	Allows certain disabled and elderly individuals who are Medicaid eligible to receive expanded services in their home as an alternative to nursing home services . Individuals participating must select an MCO

5.1 State Plan Services

There are a variety of Medicaid State Plan services available to provide needed community supports and services. State Plan Service Overview (Not an all inclusive list. All State Plan services are available based on individual need.)

State Plan Services	Medicaid
Home Health Aide Services	X
Skilled Nurse Visits	X
Private Duty Nursing Services	X
Rehabilitative Services	X
Home Health Services	X
Inpatient Hospital Services	X
Outpatient Hospital Services	X
Urgent and Non-Urgent Medical Transportation	X

5.2 Overview of Services to be utilized by *Finding a Way Home* Participants

Following are definitions of some of the most common State Plan, Waiver and MFP Demonstration services that MFP participants will utilize. This list is not all inclusive of all available services.

Medicaid Home and Community Based 1915(c) Waivers: Appendix H contains a summary description of the current wide array of options under the Medicaid 1915 C DD Home and Community Based Waiver in Delaware.. Participants enrolled in the MFP Demonstration will select the Waiver services that best fits their needs. Participants will be permitted to select only one Waiver.

1115 Diamond State Health Plan Plus Service Package- The Elderly and Disable Waiver and the AIDS waiver service package was included under the amendment to this waiver.

Following are the definitions of some of the common services that may be utilized by the MFP population:

MFP Demonstration Services:

- **Community Transition Services:** Individuals transitioning from an institution may access transition services to cover necessary costs including security deposits moving assistance, utilities hookup, and other household setup expenses. Since these transition services are not a State Plan or Waiver service, the MFP demonstration grant will pay directly for these services. Limits to any services will be explained to the participant in order for the participant to make an informed choice.

- **Social Habilitation/Community Integration Counseling:** Individuals transitioning from an institution and their family/caregivers may receive counseling sessions to assist them in integrating in the community. This includes counseling for minor difficulties the individual may have adjusting to community living. The counselor assists the individual in developing basic living skills such as budgeting, nutrition, and transit travel. Since these services are not a State Plan or Waiver service, at this time, the MFP demonstration grant will pay directly for these services.

- **Client/Family/Caregiver Education and Training on Community Services and Medical Care:** Individuals transitioning from an institution and their family/caregivers may attend workshops that inform them of the services that can be accessed in the community and the process that must be followed to access these services. Since these workshops are not a State Plan or Waiver service, the MFP demonstration grant will pay directly for these services.

- **Assistive Technology:** This service allows for individuals to avail themselves of assistive technology devices in order to function within a community setting. This is a service that is considered under State Plan services and requires prior authorization, limitations may apply. The MFP demonstration grant will pay directly any Assistive Technology devise that is not covered under the State Plan.

- **Personal Assistance Services:** This service provides assistance with any activity of daily living (e.g. grooming, meal preparation) or instrumental activity of daily living (e.g. shopping, banking, recreation) using a self-directed model. The service assists individuals to gain access to medical, social, educational, mental health, and community-based services and supports. This service is not currently a State Plan service or a waiver service. The service currently is offered in Delaware is a State funded program under DSAAPD and is

known as the Attendant Service program. However, as it is a 100% state-funded program, only a limited number of individuals can be served under the program. Therefore, the MFP demonstration grant will pay directly for these Personal Assistance services.

Finding A Way Home program participants who are in the Waiver program can access the Personal Care Waiver service once their year on the Finding A Way Home program ends. The Personal Care service is a provider managed service as well as self directed. There are no other limitations regarding this service. In addition, DSAAPD has a state-funded Attendant Care program that **Finding A Way Home** program participants may access at the end of their demonstration period.

Finding A Way Home program participants who are in the DDDS Waiver program and those transitioning from DPC can access the Medicaid State Plan service of Home Health services. Home health agencies must be certified by Medicare and be properly licensed. These services include care provided by a certified Home Health Aide. This service is available to Medicaid recipients with the following limitations: The service must be medically necessary, provided in the recipient's place of residence, and provided using professionally recognized standards of health care. In addition, more than 2 hours per day of Home Health Aide service must be prior authorized. Here again, this service does not currently offer users with ability to self-direct this service.

- **Home Accessibility Modifications:** These services are not covered under the State Plan. The MFP demonstration grant will pay directly for these services for those MFP recipients. The MCOs will also provide this service to the Diamond State Health Plan Plus participants. The State will assure payment sources for these services is a separate and distinct funding sources where applicable.

- **In-Home and Out-of-Home Respite Care:** These services are not covered under the State Plan, but are covered under the DD Waiver programs. The MFP demonstration grant will pay directly for these services for those MFP recipients transitioning from DPC who are not able to access the service via the Waiver programs.

  DSAMH will continue to provide community-based consumers with its 24 hour mobile crisis response system that has responsibility for any emergency care. This service will continue as long as the individual remains in the community. This system provides necessary supports when the individual is in crisis, including a respite bed, housing, peer supports, and even emergency psychiatric care, if merited.

- **Transition Coordinator Services:** Individuals transitioning from an institution will access the services of a transition coordinator. The transition coordinator will provide information to residents to ensure an understanding of the MFP Demonstration Grant project. The coordinator will conduct a thorough assessment to confirm eligibility, collect more information about the person's desires, needs, current services, housing preferences, and available support resources in their home/target community. The transition coordinator will facilitate the development of a transition plan and will follow the MFP participants throughout their 12 months in the demonstration. Since transition coordinator is not a State Plan or, the MFP demonstration grant will pay directly for these services.

- ***1115 Waiver services :*****Personal Care Services:** This service provides assistance with any activity of daily living (e.g. grooming, meal preparation) or instrumental activity of daily living. This is service provide a self-directed component for Waiver participants.

- **Adult Day Care:** Service assists individuals to achieve optimal physical, emotional, and social functioning which takes place in a non residential setting separate from the individual's home. Service can have a medical and/or social component and is furnished 4 or more hours per day on a regular basis, for 1 or more days per week. This service is covered under the E & D 1915c Waiver.

- **In-Home and Out-Of-Home Respite Care:** Services provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those individuals normally providing the care. While receiving services the individual cannot receive services that are duplicative in nature. These services are not State Plan services but are covered under the E&D Waiver and MR/DD Waiver. The MFP demonstration grant will pay directly for these services for those MFP recipients who are not able to access the service via the E & D or MR/DD Waiver.

- **Personal Emergency Response:** An electronic device installed in the participants home which allows them at the push of a button to receive help in a medical emergency or fire emergency. This service is provided under the E&D Waiver and is not available under the State Plan.

- **Specialized Durable Medical Equipment:** This service is a State Plan service with limitations. This service requires a prior authorization by MCO staff.

- Assisted Living

- Cognitive Services

DD Waiver Services:

- **Residential Habilitation:** Services to provide care, skills training in activities of daily living, home management, and community integration. Services can be offered in licensed, certified, or accredited group homes, residential centers, or semi-independent living situations. This service is covered under the MR/DD 1915c Waiver.

- **Day Habilitation Services:** Services to enable individuals to achieve optimal physical, emotional, sensory and intellectual functioning which takes place in a non residential setting separate from the home or facility in which the individual resides. Services are furnished 4 or more hours per day on a regular basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care. This service is covered under the MR/DD 1915c Waiver.

- **Supported Employment:** Work in an integrated setting with on-going support services. This service is furnished under the MR/DD waiver. It is not available under a program funded by either the Rehabilitation Act of 1973 or P.L 94-142.

- Clinical Behavioral Support Services

- Prevocational Services

6. Consumer Supports

6.1 Access

MFP Transition Coordinators perform education, transition assessment and assistance for institutionalized residents interested in transitioning to the home and community. Transition Coordinators provide participants with information regarding consumer rights, including the right to: select a provider; choose a preferred living arrangement and geographic area in which to reside; be actively involved in the transition process; be informed of challenges that may arise during the process; and provide input into the direction of the transition process. If participants choose to receive the MFP personal assistance demonstration service, they will be able to hire, manage and direct their own assistant. The MCOs have contracted with consumer support vendors. Transition Coordinators also perform resource and service coordination, transition assistance and post-transition monitoring. The Coordinator to candidate/recipient ratio will be 1 Coordinator to25 Candidate/Recipients. The Transition Coordinator must have the following experience, skill and knowledge:

- Experience with the multiple populations being served including those who are elderly, physically disabled, developmentally disabled, and/or those with mental health challenges.
- Experience in case management which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individual's human service needs using effective counseling or interviewing techniques as well as other available resources such as service plans or case management systems.
- Skill in interviewing, oral and written communication and interpersonal relations for effective interactions with client/family providers and agencies.
- Knowledge of community services, resources and standards of health care and service delivery.

Consumers may also receive access through the Division of Medicaid & Medical Assistance Long Term Care Eligibility units where an individual can apply for Medicaid. In addition, access may arise through identification or referral from a variety of existing providers and resources, including: institutions and facilities such as hospitals, nursing facilities, and a variety of medical, developmental disabilities, behavioral health, mental health and elderly care providers. These include Community Mental Health Centers, medical providers, public and private agencies, private providers, and home health care agencies.

Finding A Way Home program participants will have access to assistance and supports in a variety of ways. As demonstration participants are utilizing the existing waiver programs for community-based services and support, the current systems for consumer supports that are approved and in place under these waiver programs will be used by the demonstration participants as well. Waiver Case Managers work with participants to identify the demographics of their emergency/back-up plan in their person centered plan for all direct services including transportation, DME and supportive services. Back up plans (see sample in Appendix N) include a description of the risks faced when emergencies, such as lack of staff, arises. The back up plan also identifies what must be done to prevent or mitigate risk risks to health and safety: how people should respond when an emergency occurs, and who should be contacted and when. Back up plans must list how support will be provided if the lack of regular support would cause a critical situation . Back up plans will address 24-7 coverage including the need for 911 for true emergencies as well as non critical emergency 24 hour call in contact. . If it has been determined that the providing agency cannot staff the request then another provider agency shall be pursued.

Educational Materials

During application to one of the waiver programs, educational materials about the waiver, the MCO plan and its supports and services are provided to the participant. DD Waiver Case Managers provide detailed information about the 1915 C DD waiver services and supports. The MCO CM or the DD Waiver Case Manager is responsible for informing participants of how to report complaints and incidents and educating them on emergency procedures, including what to do in case of emergency and how to access back-up systems. This information is provided at the time the initial service plan is developed. This process will not change during the MFP Demonstration as the MCO CM or DD Waiver Case Manager will be actively involved in revising the plan of care and service with the participant prior to the transition to the community. In addition, the MCO CM or DD Waiver Case Manager and the MFP Transition Coordinator are responsible for maintaining contact and communication with the participant.

6.2 Back-up systems

All individuals will receive an in depth assessment prior to being approved for the MFP program. During the assessment, a listing of needs is developed and serves as the basis of a comprehensive care plan that is developed through a person-centered process with the Transition Coordinator and the MFP nurse, and the MCO CM or DD Waiver Case Manager. Participants' access to back-up supports is through several means and methods. The MCO or DD Waiver Case Manager and Transition Coordinator rely on a number of programs and processes to ensure individual health and welfare, including: provider back-up systems, contacting 911 in true emergencies and contacting the Delaware Helpline.

Back-up support is also provided for indirectly through a variety means, including: service and provider qualifications, care and service plans, contingency planning for fire and medication and a variety of other qualifications, restrictions and provisions established by rule, licensing and regulation. For example, participants can elect to have an Emergency Response System (ERS) Waiver service. The ERS is a device that allows a person to get immediate help in the event of an emergency and may also include a list of two or three other non emergency personal contacts that agree to be available for help. The person who is using the system wears a button that he or she can

push if needed. The button connects electronically to the person's phone, which is programmed to send a signal to a response center. Trained professionals in the response center then carry out a series of actions to help the person in need.

It should be noted that some individuals may choose to live in a approved CMS MFP group setting when relocating back into the community. In these instances, there will be someone physically available twenty-four hours a day, seven days a week, for the necessary protection of individuals.

Safeguards

Safeguards represent one component of back-up supports. Safeguards are requirements or provisions established or put in place in order to address potential eventualities that could occur and could require back-up support. Many safeguards are established by rules developed in accordance with enabling legislation and in accordance with the Administrative Procedures Act, both of which require a full opportunity for public input, hearing and approval. Service and support areas for which safeguards have been established include such areas as: Waiver eligibility determinations and re-determinations, both of which lead to the development of service plans and care plans; licensing and certification; service qualifications; avoidance of conflict of interest; fire safety; monitoring and quality assurance; confidentiality of information; reporting requirements; and opportunities for hearing and investigation.

The following represents a sampling of safeguards established in the Waiver rules and in service rules:

- Licensing and certification - Licensing of providers and residences is performed by several agencies. The Division of Long Term Care Resident Protection (DLTCR) within the Department of Health & Social Services develops, establishes and enforces basic standards for the care and treatment of persons in residential homes. Additionally, many health care providers require licensure and regulation. For example, the Board of Nursing regulates nurses including RN's, LPN, LNA's and MNA's (Medication Nurse Assistants). Similarly, Home Health Care Agencies require licensure and regulation. The licensing and regulation of health provider professionals and agencies help to ensure providers have appropriate education, qualifications and training as well as ongoing training and adherence to practice guidelines.

- Medicaid contract language includes conflict of interest prohibitions and limitations on providers.

- Confidentiality of information - State and federal rules and regulations identify confidential information and the limitations on disclosure.

- Reporting – Specific activities and events require reporting within a set period of time. This reporting provides for timely oversight, notice, intervention and inspection.

- Hearing – Service providers are required to provide recipients with an opportunity to appeal any decision and action following established procedures.

- Fire and life safety – all residences and homes certified or licensed by the Department require review and approval by the Fire Authority as well as an individual fire safety evacuation assessment plan, fire drills and training.

Transportation
There is currently one universal back-up system for transportation to and from medical services available to all Medicaid recipients in Delaware. Delaware Medicaid contracts with a transportation broker, Logisticare, to coordinate all non emergent medical transportation needs. The Transition Coordinator and Waiver Case Managers will provide participants with Logisticare's contact phone number, directions on how to schedule transportation, and how to report complaints. Logisticare is available 24 hours each day, 7 days each week to all demonstration participants.

For individuals with cognitive and/or developmental disabilities in the DDDS waiver, Waiver service providers, such as the residential habilitation and day habilitation providers, are responsible for transportation necessary to implement the individual's plan of care. The individual's plan of care may include various forms of transportation.

Transition Coordinators will educate and orient participants regarding available public transportation, including DART and Para transit.

Direct Service Workers
Licensed home health agencies are required by state regulation to ensure back-up services are available to the individuals they serve. They must have a telephone number where an individual receiving services can reach a person during the agency's operating hours or from 8:00 A.M. – 5:00 P.M., Monday through Friday. After normal business hours, the home health agencies have call back or on-call systems in place to respond to messages left on a machine or with an answering service and also instruct clients to call 911 in an emergency. At the time of the Waiver assessment and service planning, the participant is given contact information regarding who to call in the event of service delivery failure or to inquire about the need for additional services, etc. Back-up plans for direct care workers are included in the service plans. Individuals identify their back-up system as part of their approved plan of care. The Transition Coordinator and or CM must work with other agencies if the staffing is not available to provide service.

Repair or replacement of durable medical and other equipment
Persons in need of durable medical and other equipment are provided with information about their choices for providers in their area during the development of their service plan. This information is disseminated by the Case Manager and the Transition Coordinator during coordination efforts. The participant is given the contact information for the equipment provider and at least one alternate provider in their area. The case manager is responsible for assisting participants in locating and accessing repair to or replacement of medical equipment as needed.

Access to medical care
When individuals become eligible for Medicaid through a waiver program they also become eligible for Medicaid State Plan services. These State Plan services include access to routine medical care such as physician visits and prescriptions. The participants choose a primary care physician and can utilize any convenient pharmacy. All services are reimbursed via the fee for

service mechanism. DMMA and MCOs are responsible for maintaining an adequate number of providers and communicating relevant information about back-up and complaint systems to these participants.

MFP demonstration services
Demonstration services are available to MFP participants to assist in the process of transitioning to a qualified community residence. These include personal assistance services, transition coordinator services, respite care, home modifications, community transition services, assistive technology, social habilitation/community integration counseling, and consumer/family/caregiver education and training on community services and medical care. These services are provided for the 12 months of the demonstration and are not ongoing. Information about accessing these services will be provided by the Transition Coordinator and will be incorporated into the individual's transition plan.

Personal assistance service providers are required by contract to ensure back-up services are available to the individuals they serve. Participants will generally choose a primary assistant and at least one back-up assistant. When the primary assistant is unavailable to provide the scheduled care, the participant will contact one of his back-up assistants. If the back-up assistant is not available, the participant will contact the personal assistant service provider who will locate an available assistant from their list of assistants. Should those back-up systems fail, the personal assistant service provider will work with the participant to find another alternative utilizing the participant's back-up plan. This could involve utilizing participant's family, friends or neighbors listed on the participant's back up plan. It could also involve connecting with the participant's Waiver case manager or transition coordinator to connect with a home health agency to provide home health aide services available via the Medicaid State Plan on a temporary basis.

6.3 Complaint Resolution Process and Remediation

The Waivers implemented a policy that serves as the mechanism for reporting complaints and incidents, including failure of back-up systems that have been put into place and other issues related to waiver services and supports. The Transition Coordinators will utilize this same policy for complaint and incident reporting and remediation. In addition, the **Finding A Way Home** program will utilize the critical incident reporting process as outlined in Appendix O to further safeguard program recipients. This process describes in detail what constitutes a critical incident and to whom the incident must be reported. The **Finding A Way Home** Project Director is responsible for tracking and analyzing these incidents and developing appropriate actions. The Project Director will require the MCO staff, as well as, DDDS staff and DSAMH to provide these reporting requirements. The Project Director in collaboration with the DMMA monitoring staff assure that the MCOs follow the required reporting requirements. The MCOs contract requires the MCOs to report MFP data in addition to other 1115 required data. The Project Director continues to complete the same MFP reports completed since MFP implementation which will now including data supplied by the MCOs. If the Project Director finds the MCOs do not report as required the MFP Project Director will work with the DMMA MCO liaison for resolution and MCO corrective action.

In addition, several avenues exist for voicing complaints and defining the complaint process. As part of the complaint process, the individual is notified of and afforded numerous rights, established by rules and regulations, which provide a fundamental framework from which expectations and complaints may then arise. Complaints may be received through one or more of the following

components of the system (note - one or more complaint process may be utilized and appeal provisions are available.):

- **The management hierarchy** within any agency or organization providing or overseeing service to an individual can be the repository for a complaint. The individual can contact a provider's supervisor, manager, or oversight agency with a complaint. For example, if an individual has a complaint or concern that a service or need is not being provided or is not being provided properly, they can speak with the individual provider; and/or their supervisor; the case or service manager, nurse, area agency or a member of the licensing or oversight agency.

- **Medicaid Customer Service Unit** within DMMA. DMMA's Customer Service unit of Senior Social Worker/Case Managers can be reached via DMMA's 1-800 number from 8 a.m. to 4:30 p.m. Monday through Friday. Any Medicaid recipient can contact the unit concerning a complaint regarding the provision of any Medicaid covered service. The Customer Service Case Managers will work with the recipient and provider until the issue is resolved. The unit maintains a data base of all complaints received. DMMA reviews statistics generated by the data base for any emerging patterns and takes appropriate action as needed.

- **The contracting MCO's** are required to have a grievance and resolution procedure in place for any complaints

- **The Ombudsman Office**, The Community Ombudsman will receive, investigates and resolve complaints or problems for such individuals. Since the implementation of MFP the State hired community ombudsman who are present at MFP discharge planning meetings to address any issues and to provide contact information to the member should they have an issue post discharge. The Ombudsman remains available to receive and resolve any complaints from MFP members.

- **Adult Protective Services (APS)** In the event a complaint rises to the level of abuse, neglect or exploitation, Adult Protective Services is notified and carries out the legal requirements of the Protective Services to Adults Law. The purpose of this civil (not criminal) law is to provide protection for incapacitated adults 18 and over who are abused, neglected, exploited, or self-neglecting. APS staff are available Monday through Friday, 8:00 a.m. to 4:30 p.m. In addition, APS contracts with an agency to receive referrals after-hours.

  APS activities include:
  - Receipt and investigation of reports of alleged emotional abuse, physical abuse, sexual abuse, neglect, exploitation, and/or self-neglect, referral to law enforcement agencies as necessary;
  - Determination of the validity of the report and the need for protective services; and
  - Provision of and/or arrangement for provision of protective services when necessary and when accepted by the adult who has been determined to be in need.

- **Regulatory Authorities**. State, local and regional police, fire, health and building

regulatory authorities provide an additional check and complaint process. In times of crisis or close calls they are the first responders and point of contact and information for facts and information surrounding the incident or event. A close call or an incident can serve as a warning to a clear message that a provider, home or situation requires greater attention or scrutiny.

6.4 Responsibility to Report

DHSS, contracted service provider staff , and contracting MCOs are required to promptly make a complaint on behalf of an individual whenever they have reason to believe that an individual has been subjected to abuse, neglect or exploitation by an employee of or a consultant or volunteer for, a facility or program. This includes assisting individuals who wish to file a complaint to contact the appropriate agency or obtain advocacy services.

This involves:

- Reporting the instance of abuse, neglect or exploitation to APS,
- Taking all practicable steps to prevent the situation from recurring; and
- Notifying the Department of the issues presented and actions taken.

In addition to filing a complaint, program staff file an incident report regarding any circumstance which the policy of the facility or program identifies as an incident.

7. Self-Direction

The Division of Medicaid & Medical Assistance oversees the administration of Waivers and ensures each waiver program is in compliance with the Freedom of Choice requirement.

1115 Waiver contains elements of self-direction including a person-centered planning process and informed choice of providers. The waiver consumer, with input from his/her guardian (if applicable), may choose any willing and qualified provider(s), receive information about providers; and meet, interview and select the provider(s). The services outlined in the individual's service plan are tailored specifically to the interests, needs, and competencies of each individual. A service plan becomes effective only after receiving individual or legal guardian approval. The MFP Waiver consumer have the option of self directing personal care services. They can interview and hire their personal care assistant and direct them in areas of service such as meal preferences, how they need to be lifted/positioned, what works most comfortably for them for ADL assistance, social activities, hours of work, etc.

Through the MFP demonstration, opportunities for self-direction will continue. Transition Coordinators will educate, explain, and offer the option of self-directing services to every MFP participant. The decision to self-direct services can only be made by the individual. The MFP participant will be provided with specific procedures for voluntary or involuntary switches from self direction to provider-managed delivery systems. This information will include self direction goals and decision making authority. If an individual is capable but not comfortable when initially transitioned, they may choose a provider managed delivery system and re-evaluate and choose self direction at a later time. At any time the participant can decided to switch from a self directed

approach of services to a provider managed delivery system. In either case, the transition will appear seamless to the individual receiving services.

The MFP demonstration Personal Assistance service offers **Finding A Way Home** participants with the ability to self-direct their care. DSAAPD also offers a state-funded Attendant Care program that provides participants the option to self direct their care.
Transition Coordinators apply principles of self-direction to the use of demonstration and waiver transition services by assuring participants select qualified services of their choosing. In addition, the Centers for Independent Living (CILs) will be involved in assuring that a person-centered planning process is followed in its role as peer advocates.

The MFP Program Director and assigned MFP staff are responsible for tracking & monitoring the number of MFP participants choosing self direction.

Delaware values self-direction. Options for expanding the participant direction in the waivers will be explored through the MFP Steering Committee and the unique composition of the Stakeholders that include various Divisions' Advisory Councils as well as the Governor's Council.

8. Quality

The state will integrate the QMS for the 1115 waiver. The state will also utilize the Quality Strategy for the DD waiver when applicable.
Delaware's DDDS and DMMA within DHSS each have established Quality Management systems. Each of these Division's regularly review level of care determinations, service plan development, identification of qualified HCBS providers and health, safety & welfare issues.

To assure information about the quality of services is being sought from waiver consumers, family members, and caregivers, an annual uniform consumer satisfaction survey tool will be used. It will seek information regarding such issues as satisfaction with transition coordination, case management, individualized plans, and level of self direction.

The following is a brief overview of these systems:

Delaware Health and Social Services, Division of Medicaid and Medical Assistance's (DMMA) has developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach between DMMA, managed care, waiver, and other medical assistance programs. Delaware's QMS mission is to:

- Assure Medicaid enrollees receive the care and services identified in Waivers, MFP grant and Medicaid funded programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities;
- Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of "achieving ongoing compliance with the waiver assurances" and other federal requirements.

DMMA is the Medicaid agency who has oversight responsibility for the Medicaid and waiver programs.

Delaware's QMS plan has been developed to promote compliance with the CMS assurances and requirements with a focus on the HCBS quality framework. Delaware's QMS embodies CMS's framework for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The 1115 Waiver Quality Management Strategy is part of the MCO requirements. All quality requirements such as program integrity and assuring health and safety have been incorporated in the quality management strategy

Subsequent discussion will demonstrate how the Delaware's QMS addresses the processes of discovery, remediation and improvement; the frequency of such processes; the sources of information used to measure performance; and key roles and responsibilities for managing quality.

Delaware's QMS has been developed in a manner that promotes integration and collaboration both horizontally and vertically across state agencies and externally with key external stakeholder groups including CMS, advocacy groups, providers, and waiver clients. The following table is intended to provide an understanding of the roles and responsibilities involved in measuring performance and making improvements.

8.1 Table 1: Delaware QMS Integrated/Collaborative Model: Roles and Responsibilities

Entity	Membership	Roles and Responsibilities
Medical Care Advisory Committee	• CMS • Providers • Advocacy • Enrollees/Clients • Medicaid Leadership	• Review of QMS efforts • Forum for input from key stakeholders regarding quality efforts and key clinical management concerns • Forum for input on State policy for health care delivery to Medicaid enrollees
Medicaid Managed Care	• Medicaid Leadership • Medical Director • EQRO Consultant	• Oversight of QMS for Medicaid Managed Care and for 1915c Waiver programs. • Development of reporting to Medical Advisory Committee • Communication to and support of Stakeholder Advisory groups • Oversight and direction to the Quality Improvement Initiative Task Force
Quality Initiative Improvement (QII) Task Force	• Medicaid Quality Assurance Leadership • Representatives from all Medicaid programs • Representatives from Agency's	• Development and implementation of Medicaid QMS • Integration of Medicaid QMS with managed care and waiver quality strategies • Oversight and technical support • Provides forum for best practice sharing • Provides support and feedback to waiver

	Quality Committees responsible for waiver programs	programs for the: o Establishment of priorities o Identification, design, and implementation of quality reporting and monitoring o Review of findings from discovery processes o Development of remediation strategies and corrective action plans if appropriate • Identification and implementation of quality improvement strategies • Provides feedback on quality measurement and improvement strategies to participating agencies and program staff • Reporting to Medicaid Managed Care Quality Assurance Leadership Team
Quality Improvement Committee (QIC)	• All Divisions administering Waivers, or Division whose consumers receive DMMA state plan services • MFP Demonstration Grant	• Oversight • Priority setting • Monitoring and reporting • Establishment of priorities • Identification, design, and implementation of quality reporting and monitoring • Review of findings from discovery processes • Development of remediation strategies which may include corrective action plans • Identification and implementation of quality improvement strategies
Division of Long Term Care Residents Protection (DLTCRP)	• LTC licensing and monitoring staff	• Provider monitoring and reporting • Participation in the DMMA QII Task Force
DD Waiver, Providers	• Assisted Living providers • DD Waiver providers •	• Data reporting
Division of Public Health (DPH)	• DPH HHA &Adult Day Care facilities monitoring staff	• Provider monitoring and reporting

The following illustration is intended to demonstrate the oversight, accountability, integration across Delaware's QMS for its waiver programs. This structure promotes a highly effective collaborative approach for ongoing discovery, establishment of priorities, and development of strategies for remediation and improvement.

Table 1 provides a detailed understanding of how the processes employed to review findings from discovery activities, establishing priorities, and developing strategies for remediation and improvement are collaboration activities between the DMMA QII Task Force and Designated DHSS Division QIC staff with oversight provided by the Medicaid Managed Care The QIC has responsibility for reviewing the findings from discovery activities, establishing priorities, and assisting with suggestions for developing strategies for remediation and improvement. The QII Task Force provides a forum for collaboration and development of systematic and integrated approaches to quality activities. In a non-threatening environment, the QIC can obtain feedback on their findings from the other waiver and managed care programs & MFP demonstration, obtain technical support for establishing priorities, and have the benefit of utilizing best practice strategies with demonstrated success driving remediation and improvement activities.

Delaware's QMS has several integrated processes for compiling and communicating quality management information to internal (state agencies, state leadership) and external stakeholder (waiver participants, families, MFP participants, waiver service providers, other interested parties) groups. The following is a summary of these key processes:

- Designated waiver staff members collect and analyze quality monitoring and reporting data. These data analyses and findings are presented to the QIC on a quarterly basis. The QIC reviews these data elements to identify trends and opportunities for improvement at both the provider and program operations level. This information may then be reported to the DMMA QII Task Force during the year through a reporting schedule established by the QII. Presentations may be made during the year by designated waiver QII Task Force members to the QII Task Force utilizing this forum for feedback, sharing results and best practices. Presentations may be made quarterly by Designated MFP QII Task Force members to the QII Task Force utilizing this forum for feedback, sharing results and best practices.
- Throughout the presentation schedule, all Medicaid funded programs, including MFP and waivers program staff responsible for the waiver, MFP demonstration and managed care quality management activities may provide summaries of activities, reports, and grant opportunities at the quarterly DMMA QII Task Force meetings.
- DMMA QII Task Force compiles data and information from the quality initiative activities across the Medicaid program and develops a quarterly oversight report that is submitted to the Medicaid Feedback from the leadership team may then be disseminated through to the waiver and managed care programs through the QII Task Force.
- The DMMA MMC distributes the quarterly oversight report to the internal stakeholder group for informational and feedback purposes. This group includes all key division directors and managers.
- The DMMA MMC compiles and presents a quarterly report to the Medical Care Advisory Group for informational and feedback basis. This group includes a CMS representative, the Medicaid leadership team, Medicaid providers, advocacy group representatives, and Medicaid

participants.

- The results of quality monitoring and improvement activities are reported to Medicaid providers through the "Quality Courier" newsletter published and produced semiannually.
- This annual report summarizes quality monitoring, improvement activities, and results. This report is suitable for distribution to recipients, advocacy groups, and the general public. The summary report is posted on the Delaware Health and Social Services website for public comment.
- Agencies responsible for the waiver programs meet with provider groups on a semiannual or more frequent basis as needed. These meetings allow for sharing results from the quality management activities, incorporating feedback from the providers into quality improvement strategies, and education and training.
- The following activities are occurring on an ongoing basis to support this important communication linkage:
    - The Governor's Advisory Council for Aging and Adults with Physical Disabilities provides oversight to DSAAPD on an ongoing basis through quarterly meetings between its participants (advocacy group representatives, consumers, providers, and other key stakeholders) and the DSAAPD leadership team. DSAAPD's leadership will provide QIC updates to this group on a quarterly basis to ensure that they have ongoing knowledge of all quality management activities and have an opportunity to provide input and feedback.
    - DDDS/ DMMA/DSAMH QIC will meet with providers on a scheduled basis to provide updates on quality initiatives and obtain input and feedback on current and future initiatives. In addition, this forum will provide an opportunity to provide feedback to providers on DDDS /DMMA/DSAMH provider related quality measurement and improvement activities. This group will also serve as the source for obtaining provider support and participation from the QIC's quality studies and improvement initiatives.
    - DSAMH does an annual satisfaction survey on the service programs it oversees.
    - DMMA's provider relations agent conducts provider satisfaction surveys on an annual basis.
    - DDDS/ These data elements will be collected, analyzed, and reported to the QIC.
    - DMMA's long term care and waiver financial team conduct an annual satisfaction survey of LTC and waiver participants and/or their representatives. The QIC will incorporate these findings into their quality management monitoring and reporting activities.
    - DMMA's provider relations agent coordinates provider meetings for all Medicaid and waiver providers in Delaware on a quarterly basis. The QIC will utilize this forum for soliciting feedback and input on its quality management efforts on an ongoing basis.

8.2 Current Systems

Overview

Division of Developmental Disabilities Services (DDDS) has policies and procedures in place to ensure that the 1915(c) HCBS Waiver they administer meet CMS required assurances. They have processes of discovery, remediation and improvement to assure the health and welfare of participants by monitoring: a) level of care determinations; b) individual plans and services delivery; c) provider qualifications; d) participant health and welfare; e) financial oversight and f) administrative oversight of the waiver. All problems identified through these discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

DMMA has numerous processes to prevent and detect fraud, waste, and abuse in its medical assistance programs. Various areas of DMMA, as well as Division of Long Term Care Residents Protection (DLTCRP), , DDDS, the Attorney General's Office (AG), the State Auditor's Office, the United States Department of Justice, and the Department of Health and Human Services each contribute to the oversight, detection and prevention of fraud, waste, and abuse for DMMA. DMMA has dual overall purposes for Program Integrity of Medicaid: pre-payment education as well as prevention and detection of provider fraud waste, and abuse.

Medicaid State Plan, 1915c Waiver and MFP demonstration and supplemental services are monitored by the DMMA Survey & Utilization Review (SUR) unit. In addition, many of the state plan services are licensed and inspected by Office of Licensing & Inspection within the Division of Public Health or by the Division of Long Term Care Resident Protection (DLTCRP) on at least an annual basis. MFP demonstration and supplemental services are also monitored by DMMA MFP staff, which include a Senior Social Service Administrator, the MFP Project Director, a Registered Nurse and a Senior Social Worker/Case Manager. Onsite monitoring visits will be made by MFP staff at least annually, and more often as needed.

Within DMMA are various auditing, tracking, referral, and monitoring, education/prevention, and collection responsibilities.

- **Program Integrity**

Program Integrity Section is responsible for pre-payment prevention of overpayments by code maintenance and developing and monitoring edits and audits for the MMIS. An additional responsibility of the Program Integrity section is to ensure that all programs comply with state and federal laws, rules and regulations and also, to conduct program compliance reviews of providers participating in Medicaid waivers. Also, the Program Integrity Unit is responsible for overseeing the PERM Project. The project verifies the accuracy of payments made for Medicaid and SCHIP Programs.

Auditing the providers and recipients in DMMA's medical assistance programs is the responsibility of the Program Integrity section, primarily its SUR Unit. Data mining of claims is a technique utilized by SURS that may result in investigations, audits and prosecutions of Medicaid fraud, waste and abuse committed by providers. SUR Unit, in its audits of Medicaid providers, accesses provider information through the Medicaid Management Information System (MMIS) for investigating provider utilization and Medicaid reimbursement. The unit uses several types of exception reports to identify potential overpayments, abuse or fraud. SUR Unit also responds to complaints of questionable practices, including allegations of fraud, for initiating investigations.

The Unit conducts limited investigations and full scope audits to determine whether a provider has been overpaid or has abused Medicaid reimbursements.

The SUR Unit is concerned with the overall program integrity, including assuring that the internal system is operating in compliance with policies and procedures. This process includes State Plan services, demonstration and supplement services for all DMMA medical assistance programs.

Further, the SUR Subsystem can be used to provide data on utilization, cost analysis, testing policy adherence and testing the claims processing system for any Medicaid funded services.

The information obtained in the course of conducting business regarding any Medicaid provider or recipient is kept confidential. Only individuals with a need and right to know are permitted access to information. Information is restricted to those workers within the SUR Unit, directly involved in the specific case and others deemed necessary. Information available to the SUR Unit worker is not to be accessed or used for any purpose unless it is directly related to the performance of their job duties.

SUR performs reviews of providers to identify fraud, abuse, non-compliance and errors by billing providers. Reviews are to include (but are not limited to) in-patient services, outpatient services, home health services, physicians and pharmacies. SUR also identifies those recipients that over or underutilize Medicaid services and performs reviews.

Third Party Liability Unit is responsible for assuring that the State is the payer of last resort through accurate identification of other payers. The Estate Recovery Unit ensures maximum recovery of monies paid for Medicaid clients upon death of the client or through accidental injury settlements.

The Claims Resolution Unit ensures providers are correctly reimbursed for services allowed for by interpreting laws, rules, regulations, standards, policies and procedures for Delaware Medical Assistance Programs.

- **Planning and Policy Development**

The Planning and Policy Development section is responsible for strategic planning and program development. The section reviews CMS rules and regulations, determines the implications for the State of Delaware, and develops programs and policies. The section amends the State Plan based on CMS directives, State law changes, or DMMA policy changes. This section researches questions related to the Code of Federal Regulations and also revises and updates provider manuals. This section ensures that policies and procedures are established and that providers are educated regarding program requirements.

- **Medical Management and Delegated Services**

The Medical Management and Delegated Services section provides oversight of the Managed Care Plan contracts for assessment of accountability and performance, including access, quality of care, consumer satisfaction, and administrative capacity. The nurses within this section perform medical reviews related to claims processing and are responsible for prior authorizing services for

which a prior authorization is required. Other responsibilities include case review, disease management, Waiver oversight and provider relations. This section also has oversight of all 1915 C Waivers administered within the State.

- **Training and Long Term Care Eligibility Section**

LTC Eligibility Section in DMMA is responsible for determining LTC medical and financial eligibility for the Long–Term Care Programs.

The section determines eligibility for the traditional Long-Term Care programs, that is, Nursing Home, Children's Community Alternative Disability program, Out of State Rehabilitation, Acute Care Medicaid and the DDDS Waiver. The SSI units determine eligibility for all the QMB programs, food stamps and maintain cases for the SSI Medicaid program.

- **Management Services**

The Management Services Section of DMMA is responsible for several distinct functions, which support the work of the division. This section provides tracking of services, forecasts budget, and insures that our bills are paid along with many other items.

The units included in the Management Services Section are:

The Accounting Unit - responsible for managing the administrative expenditures, contracting, and assuring compliance with State Accounting rules.

The Reimbursement Unit - responsible for setting rates to pay direct client service providers and for forecasting expenditures and budget needs for services to clients. The nurses perform medical reviews related to claims processing and are responsible for prior authorizing services for which a prior authorization is required. Other responsibilities include case review, disease management, waiver oversight and provider relations.

The unit is also responsible for monitoring and reporting current expenditures and trends for all of our programs.

Fiscal Intermediary

Hewlett Packard (HP) is the fiscal intermediary for DMMA and is responsible for the activities of provider education, claims processing and collection activities. HP is responsible for overpayment collections and monitors, tracks and reports all overpayment recovery.

There are pharmacists at HP who oversee the drug utilization for the Medicaid program. There are two types of drug utilization review performed. Prospective drug review is a comprehensive review of drug therapy before filling each client's prescription and retrospective drug use review, which provides for ongoing periodic examinations of claims and other records to identify patterns of fraud, abuse, gross overuse, inappropriate or medically unnecessary care, among physicians, pharmacists, and individuals receiving Medicaid benefits. Although they are separate processes, they complement each other in monitoring appropriate drug usage. Prospective systems help

prevent potentially dangerous therapeutic conflicts at the point of sale. Retrospective drug review assists in the identification and reversal of long-term harmful and/or costly trends that are usually not discernible at the time of dispensing.

Division of Long Term Care Residents Protection

The Division of Long Term Care Residents Protection (DLTCRP) works to ensure and improve the health and safety of those who reside in Delaware's long term care facilities.

The Division has two main sections: the Investigative Section and the Licensing and Certification Section.

Investigative Section
The purpose of the Investigative Section is to ensure that individuals receiving services in long term care facilities are safe, secure, and free from abuse, neglect, mistreatment, and financial exploitation. The Investigative Section is responsible for:

- Operating the Complaint and Incident Referral Center (IRC), which receives complaints/incidents regarding long term care facilities and assigns them for follow-up
- Investigating complaints of alleged abuse, neglect, mistreatment, and financial exploitation
- Ensuring compliance with the criminal background check and mandatory drug testing laws and
- Maintaining and administering the Adult Abuse Registry.

Licensing and Certification Section

The purpose of licensing and certification of long term care facilities is to ensure that those facilities provide a high quality of care and quality of life to their residents. The Licensing and Certification Section is responsible for:

- Licensing long term care facilities to operate in Delaware
- Certifying nursing homes for Medicare and/or Medicaid in Delaware
- Determining and monitoring compliance with State and Federal long term care regulations and standards
- Conducting annual surveys and surprise inspections, including night and weekend visits
- Responding to complaints and incidents regarding quality of care, quality of life, and/or violations of residents' rights and
- Operating and maintaining the Delaware Nurse Aide Registry.

Division of Services for Aging and Adults with Physical Disabilities

The Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) carries out a broad range of activities to assist older persons and adults with physical disabilities. The Division operates a number of programs. One program that DSAAPD operates is the Delaware Medicare Fraud Alert Program. The Delaware Medicare Fraud Alert provides public information to encourage people who have Medicare to carefully read their Medicare summary notices and ask questions if they do not think the information is correct. This program also trains people who are retired to help other Medicare beneficiaries get the information they need when they suspect fraud, waste, or abuse of the Medicare program. DSAAPD has a toll free program contact number as well as a dedicated phone number to report Medicare Fraud in Spanish.

Division of Developmental Disabilities Services

The mission of the Division of Developmental Disabilities Services is to provide services and supports to individuals with mental retardation/developmental disabilities and their families which enable them to make informed choices that lead to an improved quality of life and meaningful participation in their communities.

This Division provides the following services:

- Community-based services including family supports, foster care placements, respite, neighborhood homes, supported living, pre-vocational, vocational and supported employment as well as day habilitation services;
- Case management**,** nursing, psychology, therapy and other professional supports to ensure that individuals receive the quality and level of supports needed;
- Early intervention services as part of the DHSS Child Developmental Watch program which works with families in order to prevent or minimize developmental delays in children at risk who are ages 0-3;
- Stockley Center which is an intermediate care facility providing residential services;
- Community education and advocacy.
- The Office of Training and Professional Development provides training and resources to support staff.

State Auditor's Office

The mission of the State Auditor's office is to provide Delaware's citizens and government leaders with professional, independent evaluations of the State's fiscal accountability and public program performance. The office has the authority to perform independent audits of the Medicaid program. A single State audit which includes Medicaid is a federal requirement and is performed each year. The office maintains a fraud, waste, mismanagement reporting hotline and internet fraud, waste and mismanagement reporting site.

Department of Justice

The responsibility of prosecution of all fraud cases lies within the Medicaid Fraud Control Unit (MFCU) section of the Office of the Attorney General. Program integrity resolution functions, including litigation support and negotiating settlements or payment plans, is the responsibility of the Office of the Attorney General. The MFCU also accesses DMMA claims data to support its investigations. Various task forces (local, state and national) also provide referrals for such investigations, audits, and prosecutions.

8.3 Assuring Health and Safety

DMMA/DDDS/ employ or contract with Case Managers who are located throughout the state. These Case Managers provide case management for individuals served by the division including waiver participants. They are responsible for determining waiver eligibility, authorizing necessary services, and frontline monitoring. Participants' input will be sought to determine if those (individuals or provider agencies) rendering or coordinating supports are providing supports in a safe manner defined by the participant. If the participant feels threatened, emergency plans will be considered until permanent plans are finalized. In addition, DDDS has a separate Quality Assurance Unit that is responsible for working with providers to ensuring corrective action is taken as required and for encouraging quality enhancement and assuring the health and safety of individuals they serve.

Participant care plans are reviewed at least annually by Division staff and as part of the review process staff ask specific questions regarding the quality and continuity of services received. When a problem is detected, the Division staff assists in the resolution of the problem and in cases of abuse, neglect, or exploitation would report to the appropriate agency to investigate and take action to protect the health and welfare of the participant.

Other state agencies, such as the Division of Public Health (DPH) and the Division or Long Term Care Resident Protection (DLTCRP) conduct certification and monitoring of community agencies that provide services for people with disabilities. This includes conducting surveys to determine compliance with certification standards (e.g. interviews with individuals and staff; review of personnel and clinical records); and survey reports to inform the agency of the findings, including deficiencies and recommendations for program improvement. Surveys are conducted at least annually and more often when problems are identified. DPH and DLTCRP have adequate surveyors on staff to complete all required surveys and inspections.

8.4 Quality Management Improvements in process

The primary system gaps relate to improvements in quality management systems that track and share individual outcomes/satisfaction and information related to quality of services. This issue is currently being addressed through the various existing transformation efforts which are exploring the use of information technology systems to improve tracking and reporting. For example, the Division of DDDS worked with consultants at HRSI in exploring and instituting performance indicators and measures. During the assessment process and development of the service plan, Transition Coordinator will discuss with the participant, guardian or family member what supplemental services are required to transition them into the community. The Transition Coordinator will work collaboratively with DDDS, DSAMH and staff in addition to the Center for Independent Living and other appropriate agencies in the area to which the participant is

transitioning in order to ensure that their needs are met and barriers to residing in the community are addressed. MFP staff, taking into consideration the recommendation of the agencies involved in the transition, will give final approval of all funds and services. Throughout the duration of the demonstration period, contact will be maintained with the participant at least monthly to ensure the service plan continues to adequately meet their needs and that their quality of life in the community meets their expectations. MFP staff will track how Supplemental Demonstration services were used and their effectiveness in supporting successful transitions.

Delaware's QMS infrastructure has been developed and implemented in recognition that quality management is an ongoing, evolving, dynamic effort when it comes to monitoring and improving the delivery of health care services to the targeted high risk populations in its waiver programs. Through the process of capturing and collecting data on all aspects of the program and trend analysis, the state is able to make program changes and improvements in a collaborative manner with the provider community and advocacy groups.

DMMA's oversight authority consists of monitoring the quality strategies of all waiver and Medicaid funded programs through the QII task force. The following is an overview of this process:

- DMMA leadership works closely throughout the year to support, oversee, monitor, and evaluate the quality management activities;
- The EQRO provides ongoing technical support to DMMA in the development of oversight monitoring strategies and ensuring the Medicaid leadership stay informed on new state and federal requirements and the evolving technologies for quality measurement and reporting;
- The information from the previous two bullets and other DMMA activities is utilized by DMMA to perform an annual assessment and update as needed of the States QMS including:

- Reviewing and assessing the quality improvement efforts and results from the previous 12 months for the managed care and waiver programs;
    - Reviewing the feedback obtained from the Medicaid leadership team and Medical Care Advisory Committee (MCAC), including feedback from the provider community, advocacy, and CMS participants) throughout the year regarding the State's quality management activities;
    - Identifying new goals and objectives for the next year with feedback from the QII task force, Medicaid leadership team, and MCAC.
- DMMA and its External Quality Review Organization (EQRO) reassess and update the QMS as needed based on the activities described above. The updated strategy is reviewed with the QII task force to obtain their input and feedback.
- The QMS is then updated and reviewed with Medicaid leadership team to obtain their input and feedback.
- Once the QMS is updated with this feedback, it is then shared with the MCAC as an opportunity to incorporate provider, advocacy, and beneficiary input into the strategy.
- The QMS is finalized and shared with the QII task force members and other key stakeholders (e.g., agency directors)
- The QIC and QII Task Force structure supports the identification and prioritization of immediate and long-term remediation strategies.

9. Housing

9.1 Documentation of Qualified Residence

Individuals who are participants in this demonstration will be transitioned to a variety of qualified community settings and residences. Through the support of Transition Coordinators, each participant will be supported to create a person centered transition and community plan that will assist the individual to identify and access a variety of paid and unpaid supports and to achieve an inclusive lifestyle of their choice in the community.

Each plan will identify the type of residential setting to which the individual will transition and the supports needed for them to live quality lives in each setting. Transition Coordinators will also assist these individuals in applying for housing assistance and supports (e.g. Housing Choice vouchers) or other affordable housing .

Delaware State Housing Authority conducts Statewide Housing Needs Assessments every 5 years as part of their consolidated planning process. The last one completed in 2007 identified a need for a comprehensive listing of affordable housing opportunities. In April 2008, DSHA added a housing locator to the DSHA website at www.de.housing .com. this housing locator includes information about accessibility of units. Currently the locator informs people about the location of affordable housing and contact information, but not the availability of units within these apartment communities.

Delaware will only enroll an individual in the MFP demonstration to a setting that meets the definition of a "qualified residence" as defined in Section 6071(b) (6) of the Deficit Reduction Act. Information on the type of qualified residence that an individual chooses is verified at the time the participant is enrolled in the MFP demonstration and in the 1915(c) waiver. This information will be recorded by the Transition Coordinator in the individual's transition plan and will be passed on to the MFP Project Director. The Project Director will retain this information in each MFP participant's case file. This information will also be data entered into the MFP data base maintained by DMMA.

Each MFP case file maintained by DMMA will contain documentation regarding the facility from which the participant was discharged and the duration of the institutional stay to validate the participant meets this criterion. In addition, the case file will contain information indicating the person is transitioning to a qualified community residence, which may be one of the following types of residences:

- A home owned or leased by the transitioning individual or the individual's family member.
- An apartment with an individual lease, which has:
  - lockable access and egress,
  - living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control.

    This may include public housing units.

Please note - Delaware does not license or regulate a home owned or leased by the individual or the individual's family member.

- A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside. This may include the following licensed arrangements:

    - Adult foster care homes
      Adult foster care is a setting that provides a twenty-four hour living arrangement in a DHSS enrolled foster home for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care and nursing tasks; help with activities of daily living, supervision and the provision of or arrangement of transportation.

    - Group home with 4 or less individuals.
      A residence in which no more than four individuals and other persons receiving similar services are living at any one time; the provider is present in the residence and is awake whenever an individual is present in the residence; the program provider holds a property interest.

        - A housing unit shared by 4 or less unrelated adults where all tentants are on the lease.

9.2 Assessment of Housing Needs

The Delaware State Housing Authority (DSHA) completed a Statewide Housing Needs Assessment in September 2007, which identified the inventory of affordable rental housing in the State. By March 2008, DSHA completed inventory of accessible affordable units in the State. This inventory will be available on the DSHA website via the Housing locator which is a searchable database of all affordable multi-family sites in Delaware. People are able to search by location, features and price and then contact those sites that have units that meet their criteria to learn about availability and the application process. The Housing locator is available on the DSHA . DSHA assumes responsibility for updates to this site.

The Statewide Housing Needs Assessment could not quantify the number of people in institutions who are in need of affordable housing to move into the community. However, it is clear that affordable housing is an issue for people who are unable to work due to a disabling condition and must rely on Social Security benefits. The Housing Needs Assessment provided the following information about this population:

- According to the Kaiser Family Foundation's health statistics web page, there was 82.3 percent occupancy of nursing home beds in Delaware in 2005.
- Nearly 60 percent of DE residents in nursing homes are paid for by Medicaid, which means they are low-income with very few assets; 16 percent are paid for by Medicare, which usually means it's a short term rehabilitation stay, and 25 percent are private pay.
- The Minimum Data Set, a client survey instrument, indicates that as of the 2nd quarter of 2007, 20.4 percent of people living in nursing homes (792 of 3,886) would like to live

independently. The survey does not indicate what barriers prevent those individuals from doing so.

In addition, the Statewide Housing Needs Assessment looked at American Community Survey (ACS) data to determine the poverty rate among people with disabilities and found that;

> "The 2000 Census reported that the poverty rate in Delaware for persons with a disability age 16 to 64 was 13.61 percent. For persons with a disability age 65 and above, the rate of poverty was 7.4 percent. Nearly 50 percent of the persons age 16 to 64 living with a disability in Delaware reported not working. An update on poverty statistics for the disabled from the 2005 ACS indicates the rate of poverty for persons with a disability age 16 to 64 increased to19 percent; for those age 64 and above, the rate increased to 10.1 percent."

A basic finding of the Statewide Housing Needs Assessment is that there is an insufficient supply of affordable housing in Delaware to address the needs of people with extremely low incomes. Funding sources for creating new housing have been reduced and existing affordable housing is aging and falling into disrepair. DSHA has a priority of preserving existing affordable housing as, if these units are lost, rental subsidy associated with the units would also be lost.

DSHA and DHSS/DMMA have applied for the Melville Housing and Supports 811 funding offered by HUD. DHSS is in the process of forming a partnership with DSHA to handle project based integrated 811 funding and DHSS/DMMA to be available to supply services needed for qualified tentants. DHSS/DSAAPD has a Housing Coordinator team to address the SRAP program and work with DSHA to formulate the HUD NOFA for integrated 811.

9.3 Strategies to Meet Projected Housing Needs

Delaware has committed to serve the projected 231 people transitioning under MFP due in part to the significant barriers posed by the affordable housing crisis. A Transition Coordinator well versed in housing resources will assist each person transitioning to the community. DSHA has agreed to provide the Transition Coordinators with training and tools to assist them in accessing affordable housing resources throughout the State. The Coordinator will assess the person's housing needs early in the identification process and will advocate for and intercede on their behalf to obtain the needed housing. The types of supported housing can be found in Appendix G.

According to affordable housing development site managers and DSHA staff there are more affordable apartments with accessible features than there are applicants who need those features. Five percent of all new units are required to be handicapped accessible and DSHA works with developers to ensure that all first floor units in affordable housing developments assisted by DSHA are easily adaptable. Currently, accessible units are often rented to people who do not require the features. When the units are rented to people without disabilities, those tenants are told that they will need to relocate to the next available unit when a qualified tenant applies who needs the features. DSHA will work with Transition Coordinators to ensure that these units are made available to qualified MFP participants. Please note, this does not mean that there is a sufficient supply of affordable housing available. It just means that handicapped accessible units are often made available to non-disabled individuals.

DSHA has developed a housing locator that identifies affordable housing developments that have accessible units. This housing locator is available on the DSHA website . People with disabilities and those who assist them will be able to identify where in the State affordable accessible units are located and then call to find out if current residences are in need of the accessible features. DSHA will provide training on the locator to Transition Coordinators in addition to providing them with a paper guide to housing resources.

At the same time the MFP Steering Committee will continue to work with other organizations, such as the Housing committee of the Governor's Commission, to develop a long-term strategy for transitioning people from institutions that will ensure housing choice, affordability and housing stability. The following efforts will be encouraged:

- ☐ Creation of preferences for Public Housing Authorities' low-income housing programs for the population transitioning from institutions. The state will contact Delaware's 5 Public Housing Authorities (PHA) and request to present at meetings. The state will encourage PHAs to commit a number of housing vouchers to individuals who are transitioning out of nursing facilities and habilitation centers.
- ☐ Creation of a rental assistance program for the population transitioning from institutions with available support services.

- ☐ Creation of a website where information about available units for rent and for sale, that have accessible features can be posted.

10. Continuity of Care Post Demonstration

The majority of participants in Delaware's Finding A Way Home Demonstration will receive home and community based services through waivers that are currently in place. Participants will continue to receive services without interruption or modification at the end of their participation in the demonstration via the 1115 Waiver or HCBS Waiver in which they are enrolled.

The Waiver programs involved have sufficient capacity to accept an increased number of applicants through this project, with the assumption that each new program participant will continue to be served after the end of the first year of community based service provision. DDDS has a provision built into its current /DD 1915(c) Waiver that reserves capacity for individuals transitioning from an ICF/MR. In both waiver programs, eligibility for the waiver will be determined in conjunction with eligibility for the MFP program. MFP participants will enter a waiver slot at the onset of transition into the community; once they reach the end date of grant participation they will remain in the same slot.

The services provided during the grant will continue to be provided once the one year period is over, with the exception of the MFP demonstration services.
Individuals transitioning from Delaware's IMD facility, the Delaware Psychiatric Center, who are not eligible for any waiver program will continue to access all available Medicaid State Plan services without interruption at the end of their participation in the demonstration. DSAMH offers individuals transitioning from DPC a Case Management program that includes psychiatric services, rehabilitative services, and the normal complement of an ACT team case management model. In addition these individuals can access a day program and are assisted in addressing any other needs that might emerge while they are in the community. All of these services are offered by the

DSAMH Community Continuum of Care Program (CCCP), which include a community based Case Manager who follows these individuals in the community. These services are available to individuals while they are on the Finding A Way Home program and after their year on the program ends.

Systems changes in the MMIS for the purpose of tracking Finding A Way Home participants and completed the required reportin**g** were completed. The **processes are** seamless to the participant.

In addition, post-transition continuity of care will be assured for each program participant through the following mechanisms:

1. The MFP assessment and transition planning process will identify all barriers to a successful transition for each person who applies to the MFP Project and will develop strategies to overcome each barrier. The process will:
    a. Assess the person's needs;
    b. Assess the person's expectations;
    c. Assess the person's social support network in the community to which s/he wishes to transfer;
    d. Identify how a successful transition can be supported;
    e. Identify individuals for whom a transition is either not feasible or is medically contra-indicated and compare that to how far the project can flex to meet needs; and
    f. Develop an action plan that assigns specific staff and services with expected outcomes and accountability.

2. The person-centered planning process will begin on the day of referral, and will ensure swift movement through the eligibility and service planning process.

3. The service plan that is developed prior to each transition will include:
    a. A sustainability plan to avoid a disruption in necessary services:
    b. A plan for oversight to ensure safety and service viability and to establish the relationship between the participant and the individual who will be monitoring.
    c. A community living site visit whenever practical to evaluate service availability at that location

C. Organization and Administration

1. Organizational Structure

The Department of Health and Social Services (DHSS) is responsible for delivering Long Term Care (LTC) services to Delaware's elderly and disabled populations. Within DHSS, institutional and community-based long term care services are provided by four divisions: the Division of Medicaid and Medical Assistance (DMMA), the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), the Division of Developmental Disabilities Services (DDDS), the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH).

DMMA is the lead organization responsible for Delaware's MFP Initiative. DMMA is working collaboratively with the DDDS, DPH, DSAAPD and DSAMH to successfully implement, monitor and operate the demonstration.

DMMA is the single state agency that administers the Medicaid program. Its Long Term Care units determine financial eligibility and perform level of care assessments for the nursing facility and other LTC programs. DMMA oversees the administration of 1915c Home and Community Based Service (HCBS) waiver DMMA supports the move to consumer-directed, home and community-based services for LTC and is committed to ensuring LTC policies are in place that promote fiscal responsibility and assure equal access to Medicaid services and supports.

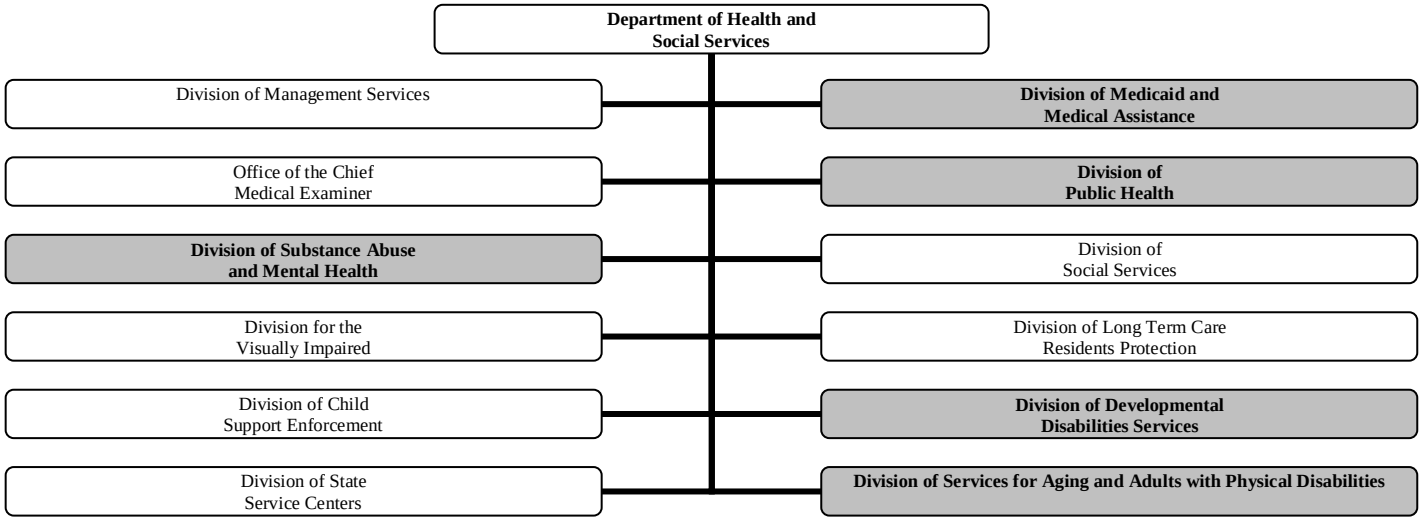
DSAAPD engages in various activities to carry out its mission, including direct services and programs (e.g., Community Services Program and LTC Ombudsman Program) and administers contracts for home and community based services (e.g., adult foster care; assistive devices; attendant services; respite; Hispanic outreach; home modification; housekeeping; personal care).

DDDS operates the 1915c HCBS Waiver program for individuals with cognitive and developmental disabilities. DDDS provides community-based services, case management services, nursing, psychology, therapy and other professional supports. It also operates the Stockley Center, Delaware's state-operated Intermediate Care Facility for people with Mental Retardation (ICF/MR).

DSAMH provides services for adults with serious psychiatric disorders and drug, alcohol, and gambling addiction services. DSAMH operates the 360-bed Delaware Psychiatric Center (Delaware's only psychiatric hospital for adults), two community mental health centers, public drug and alcohol treatment services for adults, supported housing services, and other community supports. DSAMH's mental health services system includes community-based inpatient services, Community Mental Health Centers, and a variety of community-based services and programs to help maintain clients in the community. The DSAMH-funded substance abuse treatment system offers a similar mix of community-based approaches.

DSAAPD operates Delaware's three state-run nursing facilities: The Delaware Hospital for the Chronically Ill, with 400 licensed beds providing intermediate and skilled care; the Emily P. Bissell Hospital, with 102 beds providing intermediate and skilled care; and the Governor Bacon Health Center, a 94-bed facility providing intermediate care.

Please see the organizational chart below that outlines each of the Divisions and the relationship to the Medicaid agency.



2. Staffing Plan

Delaware created a new position at the implementation of this grant to serve as the MFP Project Director that was funded by the grant. This is a full time Social Service Administrator position, Budget Position # 66004, within the Division of Medicaid and Medical Assistance's Medical Management unit. 100% of this position is dedicated to the MFP Demonstration.

The primary role and responsibility of the Project Director is to direct and assist the activities for Delaware's Finding A Way Home demonstration. This includes: reviewing and developing policies; serving as liaison with interested groups, individuals, agencies, and the legislature concerning the demonstration; developing and implementing any needed rules, regulations, standards, and controls for carrying out and completing the demonstration; monitoring the budget for the assigned programs; completing required federal reporting; and performing other related duties.

DMMA also created a new position of Marketing & Housing Coordinator, which will coordinate all marketing and outreach efforts and focus on issues surrounding housing for the MFP program. There are many other positions within DHSS providing in-kind support to the project but are not directly paid for by the MFP Demonstration grant. Some of these were new positions obtained in the State Fiscal Year 2008 budgetary process.

Positions Providing In-Kind Support

Name	Title	Division	Roles and Responsibilities	% of Time Contributed to MFP project
Glyne Williams	Social Service Chief Administrator	DMMA	Oversees Delaware's 1115 Waiver program, Medicaid MCOs, 1915c Waivers, Diamond State Partners	5%

			program.	
Nancy Kling	Health Care Cost Containment Specialist	DMMA	Supervisor of MFP Project Director, Oversee the administration of the MFP Demonstration and Delaware's 1915c HCBS Waiver programs.	30%
Goldie	Management Analyst III	DMMA	Responsible for monitoring program expenditures, compiling programmatic data for management evaluations and completed required reports.	50%
Vacant	Registered Nurse III	DMMA	Reviews level of care and physical eligibility for MFP recipients. Reviews and approves medical plan of care. Involved in program oversight functions.	25%
Chrissy Sapp	Registered Nurse III	DMMA	Reviews level of care and physical eligibility for MFP recipients. Reviews and approves medical plan of care. Involved in program oversight functions.	50%
Lawanna Waterman	Temporary Administrative Specialist	DMMA	Provides administrative support. Creates word documents; creates and maintaining databases and spreadsheets; and creates presentations. Coordinates meeting and composes correspondence.	75%
Andrea Wozny	Social Service Administrator	DSAAPD	Assists with the DSAAPD nursing home transition project	50%
Rotira Johnson	Sr. Social Worker/Case Manager	DMMA	Reviews assessment care planning and assures service linkage for individuals transitioning from nursing facilities. Authorizes services identified in care plans to meet the personal, social health and financial needs of clients and/or their families making this transition.	75%
Jennifer Harris	Sr. Social Worker/Case Manager	DMMA	Reviews assessment care planning and assures service linkage for individuals transitioning from nursing facilities. Authorizes services identified in care plans to meet the personal, social health and financial needs of clients and/or their families making this	75%

			transition.	
Marge Turner	Sr. Social Worker/Case Manager	DMMA	Reviews assessment care planning and assures service linkage for individuals transitioning from nursing facilities. Authorizes services identified in care plans to meet the personal, social health and financial needs of clients and/or their families making this transition.	75%
Gale Hartley	Sr. Social Worker/Case Manager	DMMA	Reviews assessment care planning and assures service linkage for individuals transitioning from nursing facilities. Authorizes services identified in care plans to meet the personal, social health and financial needs of clients and/or their families making this transition.	75%
Gail Weinburg	Community Ombudsman	DSAAPD	Serves as primary representative/advocate of home & community based consumers state-wide. Conducts professional investigations of complaints related to the treatment of individuals residing in community based settings.	75%

3. Billing and Reimbursement Procedures

DMMA utilizes billing and reimbursement procedures in order to insure against duplication of payment for the demonstration and Medicaid programs; to provide for fraud control and monitoring. This includes maintenance of an active "SURS" Medicaid Unit. The Surveillance Utilization Review Subsystem (SURS) pro-actively monitors program integrity as well as suspect providers who potentially over-bill for services. Various onsite or desktop audits are performed to monitor service provider billing practices. Occasionally, some audits lead to civil or criminal prosecution. The SURS Unit conducts post-payment reviews on random select claims.

The majority of the MFP service claims will be processed through DMMA's MMIS. Within the MMIS edits and audits access provider, recipient, and reference data during the adjudication process for validation of allowed provider services, recipient eligibility, and various codes, their usage and allowable payment cross checks. As a result of the adjudication process, claims are suspended, denied or approved to pay. Within the MMIS there is a set of audits that check for duplicate claims and or suspect duplicate claims. Claims that are exact duplicates deny, suspected duplicate claims are suspended to a location for review. Claims that suspend are manually resolved. Suspended claims are either forced to pay or deny, and are then reprocessed through the MMIS. Once a claim has been finalized – that is either approved to pay or denied, it is included in the MMIS weekly

Financial cycle. All claims and their status are reported on for a given provider in their Remittance Advice (RA).

All other MFP invoices will come directly to the Project Director for validation of the services rendered. They will then be forwarded to the Fiscal and Accounting Unit within DMMA for payment processing.

The MCOs have been given a code matrix to bill for MFP services. In using this matrix, the State ensures no duplication of services takes place. For example, the transition coordination service has six different codes to bill for depending on the service provided.

D. Evaluation

Delaware is not pursuing additional evaluation of unique design elements of its MFP Demonstration program.

E. Revised Budget

1. Administrative Budget Narrative

1.1 Personnel

Full-time staff supporting the implementation of the demonstration include:

- *Project Director* – The Project Director will oversee the day to day operation of the demonstration. The project director will be responsible for CMS reporting, MFP contract management, and overseeing the stakeholder process.
- *Marketing & Housing Coordinator* – The Marketing & Housing Coordinator will oversee all marketing and outreach activities for the MFP program. In addition, she will be responsible for addressing all activities to expand housing opportunities for individuals to be served under the program.

The State requested an RFP but the vendor did not accept the terms of the contract.

Service Budget Narrative

The costs below are based on the number of transitions estimated annually for the MFP Demonstration grant.

- **Community Transition Services:** These services include the cost of covering security deposits, moving assistance, utilities hookup, and other household setup expenses. It is estimated that 21 participants will access these services in CY 2009 (the first full year of demonstration services) at an average annual cost of $2,500 per person.

- **Social Habilitation/Community Integration Counseling:** This service consists of counseling sessions to assist participants in integrating in the community. It is estimated that 34 individuals will access these services in CY 2009 at an average annual cost of $960.

- **Client/Family/Caregiver Education and Training on Community Services and Medical Care:** This service consists of workshops that inform participants and their families of the services that can be accessed in the community and the process that must be followed to access these services. It is estimated that 34 individuals access these services in CY 2009 at an average annual cost of $3,000 per person.

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- **Assistive Technology:** This service allows for individuals to avail themselves of assistive technology devices that are not covered under the Medicaid State Plan or under any HCBS Waiver program. It is estimated that 15 participants will access this service in CY 2009 at an average annual cost of $2,500 per person.

- **Personal Assistance Services:** The Department has issued a request for proposals (RFP) for this demonstration service. This service provides assistance with any activity of daily living (e.g. grooming, meal preparation) or instrumental activity of daily living (e.g. shopping, banking, recreation) using a self-directed model. It is estimated that 12 participants will access this service in CY 2009 at an average annual cost of $43,680 per person.

- **Home Accessibility Modifications:** It is estimated that 11 participants will access this service in CY 2009 at an average annual cost of $5,900 per person.

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- **Transition Coordinator** - The Department has hired state staff to provide Transition Coordinator services. The Transition Coordinator will provide comprehensive assistance to individuals seeking to transition from nursing facilities into the community. The costs are based on the number of transition coordinators working for the ***Finding A Way Home*** Demonstration program. . These Transition Coordinators will continue to provide services to the DD and MH population that do not meet 1115 criteria who do not meet the amended 1115 Waiver requirements

II. Appendices

Appendix A. MFP Budget

Not included

Appendix B. MOE Form

Not Included

Appendix C. Informed Consent Form

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

FINDING A WAY HOME PARTICIPATION & CONSENT AGREEMENT

PARTICIPANT NAME:	**Medicaid #:**

SUMMARY

Finding A Way Home, Delaware's Money Follows the Person Demonstration, is designed to assist individuals who wish to transition from institutions into the community. The Finding A Way Home Demonstration's intent is to eliminate barriers to receiving services and to ensure delivery of quality services.

AGREEMENT

- I understand that I must be eligible for Delaware Medicaid in order to participate in the Finding A Way Home Demonstration.

- I understand that my participation in the Finding A Way Home Demonstration is for a period of one year from the date of my transition into the community. My home and community based services will continue uninterrupted and without reduction following the demonstration period, as long as there is a continued need and all eligibility requirements are met.

- I understand that I can get the following demonstration services, but that these services are not ongoing and will terminate after my year of participation in the demonstration.

  - ❖ Personal assistant services (your Transition Coordinator will work with you to assure that you receive a similar service once your personal assistant service ends.)
  - ❖ Respite care and personal care services to recipients with serious mental illness
  - ❖ Home accessibility modifications
  - ❖ Assistive technology
  - ❖ Community transition services including security deposits, moving assistance, utilities hookup, and other household setup expenses.
  - ❖ Social habilitation/community integration counseling
  - ❖ Individual/Family/Caregiver education and training on community services and medical care.

- I agree to participate in the Finding A Way Home Demonstration. I understand that I will be asked to complete three short surveys about my quality of life. I understand that I am encouraged, but not required, to participate in these surveys that will help demonstrate the

success of the project.

- I have been informed of the complaint process and safety plan to safeguard against risks associated with moving to the community.
- I understand that agreeing to participate in the Finding A Way Home Demonstration has no impact on my eligibility for any other program.
- I understand that I have the right to end my participation in the demonstration at any time during the one year period.
- I have reviewed this form and understand that my signature acknowledges agreement in participation in the **Finding A Way Home** Demonstration.
- I understand that the Federal and State laws will be followed regarding the sharing of my personal health information.
- My signature below indicates that I agree to participate in the Finding A Way Home Demonstration if I am determined eligible.

PARTICIPANT SIGNATURE	DATE
GUARDIAN SIGNATURE	DATE

As guardian, I agree to facilitate successful participation of _____ in the Finding A Way Home Demonstration.

If at any time you have questions call Division of Medicaid & Medical Assistance, Finding A Way Home Program at: 800-372-2022.

WILL BE USING PAE FORM OF 1115 AMENDMENT

Appendix E. Self-Direction

Money Follows the Person Rebalancing Demonstration
Operational Protocol

I. Participant Centered Service Plan Development

a. Responsibility for Service Plan Development. Specify who is responsible for the development of the service plan and the qualifications of these individuals (check each that applies):

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☒	Case Manager. Specify qualifications:
	Applicants must have education, training and/or experience demonstrating competence in each of the following areas: Experience in case management which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individuals human service needs using effective counseling or interviewing techniques as well as other available resources such as service plans or case management systems. Experience in making recommendations as part of a clients service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits. Experience in interpreting laws, rules, regulations, standards, policies, and procedures. Experience in using an automated information system to enter, update, modify, delete, retrieve/inquire and report on data. Experience in narrative report writing.
☐	Social Worker. Specify qualifications:
☐	Other (specify the individuals and their qualifications):

b. Service Plan Development Safeguards. Select one:

☒	Entities and/or individuals that have responsibility for service plan development may not provide other services to the participant.
○	Entities and/or individuals that have responsibility for service plan development may provide other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as

appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Participants are furnished with the MFP Consent Form during the preparation & enrollment into the Waiver and MFP program. These forms provide information about services available under the MFP & 1915 C Waiver and 1115 Waiver programs. The Finding A Way Home Participant Rights & Responsibilities form gives information about participants' rights and who to contact for questions and concerns regarding MFP services. Prior to the establishment of the care plan the Waiver CM & Transition Coordinator will review the forms with the MFP participant and/or legal guardian or representative. The participant has complete authority to bring to the service plan meeting(s) whomever he/she would like to include in the process. In fact, the participant will be actively encouraged to bring others to these meetings

d. Service Plan Development Process. In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The individual participant is the central figure in the development of his/her Waiver & MFP care plan. Participants are encouraged to bring family members and/or other interested persons to participate in the development of their MFP care plans. Service providers may also participate in the MFP care plan development process, along with the case manager and Transition Coordinator. MFP & Waiver care plans must be developed and approved prior to or on the date of a participant's receipt of services. The care plan is updated at least annually by the case manager. The Waiver redetermination process takes place through an in-person visit. Also, revisions are made to MFP care plans more frequently, as needed. Revisions are triggered by changes in a participant's service needs observed and documented by case managers during scheduled monitoring visits.

Initial screening for MFP is conducted by the Transition Coordinator. DMMA, DDDS & DSAMH staff are also involved. The level of care assessments are performed by DDDS staff, nurses as part of the Waiver eligibility determination process.

Follow-up assessments are also conducted prior to the MFP care plan process by case managers.

Such assessments are carried out by reviewing physical evaluations as well as through in-person interviews with participants. These assessments are designed to secure information about participant strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors.

The case manager has principle responsibility for informing participants of services available

under the 1915 C waiver. The Transition Coordinator is also involved and is responsible for information participants of services available under the MFP demonstration. As part of the service planning process, the Waiver case manager and Transition Coordinator review program information with the participant, including a list of available providers, as well as information related to:

- MFP service & program requirements
- Patient Pay Amounts
- Freedom of choice of providers
- Care plan negotiation
- Non-medical leave policy
- Fair Hearing options
- Hospitalizations
- 12-Month Re-determination process
- Participant responsibilities
- Managed Risk
- Hospice Options
- Medicare Part D prescriptions

Written information related to the program is presented to participants through the Awareness Form.

As noted above, the individual participant and the participant's legal representative is the principal participant in the MFP care plan development process. He or she is encouraged to have family members or other interested persons present at the MFP care plan meeting to make sure that individual needs, preferences, and goals are communicated and understood. The MFP care plan form itself is designed to include narrative information on special needs for each activity and service listed in the agreement.

Health care needs (including physical health and mental health) are addressed specifically in the service planning process. The MFP care plan addresses needs such as health maintenance (medication management, monitoring of health status) and special medical needs.

Services for a participant enrolled in the MFP project are coordinated by the case manager. Each participant has a written MFP care plan that specifies the type of assistance or special needs for that particular participant. In addition to the ADL and IADL assistance needed, the MFP care plan also addresses routine health care, medications, transportation, EPSDT services and special needs covered under the Medicaid State Plan & non Medicaid covered services and notes who is responsible for providing this care. The case manager is responsible for following up to see that the participant's needs are met. For participants living in group residences, the case manager will coordinate with staff designated by the residence. The review/monitoring of the MFP care plan, which includes non-waiver as well as waiver services, takes place as described below.

The case manager is responsible for overseeing and monitoring the implementation of the MFP care plan. Specifically, case managers who are involved in the development and approval of an MFP care plan monitor and document its implementation. These case managers are also involved in the revision of MFP care plans, as needed.

The case manager and Transition Coordinator are responsible for orienting participants regarding the concepts of self direction. The Personal Assistance service provider is responsible for helping the MFP participant learn how to self direct and manage their personal assistant.

Follow-up visits are made by case managers on a scheduled basis and if, on the basis of these contacts it is evident that service needs have changed, individual MFP care plans are revised. Case managers are required to contact each participant in person monthly and update plans at least annually.

Case managers also respond to changes in participant conditions noted by other parties involved.

Changes in condition are reported through the following processes:

• Service providers, report all significant changes in functional level to case managers
• Designated State Agency nurses (following annual eligibility re-determination visits) report significant changes in functional level to case managers
• Family members, physicians and/or other interested persons report significant changes in functional level to case managers
Case managers make adjustments to MFP care plans, as needed, in response to these reported changes in participant conditions.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A key objective of the risk assessment process is to promote individual choice while minimizing the risk to MFP participants. As described below, the MFP care plan development process includes risk assessment and, on an as-needed basis, the development of a managed risk agreement. This process ensures that MFP participants make independent choices with an understanding of related risks.
Risks are assessed during the initial participant assessment process and during the development of the MFP care plan. As part of these processes, participant heath status and support needs are determined, along with individual participant preferences. These factors are ascertained through physical evaluations as well as participant interviews. When it is determined that participant preferences present identifiable risks, a managed risk agreement is incorporated into the MFP care plan.
The following are criteria for a managed risk agreement:
• The risks are tolerable to all parties participating in the development of the managed risk agreement;
• Mutually agreeable action is identified which provides the greatest amount of participant autonomy with the least amount of risk; and
• The participant is capable of making choices and decisions and understanding consequences.
If a managed risk agreement is made a part of the MFP care plan, it will:
• Clearly describe the problem, issue or service that is the subject of the managed risk agreement;
• Describe the choices available to the participant as well as the risks and benefits associated with each choice, the service provider's recommendations or desired outcome, and the participant's desired preference;
• Indicate the agreed-upon option;
• Describe the agreed-upon responsibilities of the service provider, the participant or the participant's legal representative , and any third parties;
• Become a part of the MFP care plan, be signed separately by the participant or the participant's legal representative , service provider, and any other third party with obligations under the managed risk agreement; and
• Include a time frame for review.
Back up plans become part of each MFP care plan.
For example, back-up plans for physical emergencies, such as fires or other natural

disasters, are required. Make provisions for back-up staffing, as needed. Plans are in place at the individual level for back up services and supplies. A list of alternate providers is provided in the event that a primary provider is unable to deliver the service/supply, a secondary provider is contacted.
Individual back-up plans will be in place for services included in the MFP care plan. Case managers will maintain lists of alternate service providers (along with contact information) to carry out needed support activities to safeguard the health and welfare of the participant should the regular provider become unavailable. The participant and or case managers will contact the back-up providers and schedule services as needed.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

The Waiver Case Manager provides the individual with information regarding all enrolled Waiver providers and the participant is able to choose any of these providers. The participant can elect to interview the provider(s) prior to making a final choice. The Transition Coordinator provides the individual with information regarding all enrolled MFP Demonstration Service providers. The participant is able to choose any of these providers. Here again, the participant can elect to interview any provider prior to making a final choice.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

Prior to the development of a MFP care plan, participants and/or their legal guardian or representative are provided with an Awareness Form which includes information about the freedom to choose among providers. Participants and/or their legal guardian or representative are also given a list of providers and can choose among these service providers. This list can be made available to a participant and/or their legal guardian or representative at any time during his/her enrollment in the MFP program.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Finding A Way Home project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (check each that applies):

☐	Medicaid agency
☒	Operating agency
☒	Case manager
☐	Other (specify):

II. Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Division of Developmental Disabilities Services (DDDS) the operating agency, DMMA have a memorandum of understanding detailing roles and responsibilities under the MR/DD 1915 C waivers.
As part of this memorandum, the MFP/HCBS care plan oversight responsibility of DMMA is delineated. Specifically, DMMA will be responsible for overseeing the review of the case manager's care plans.
DDDS/DMMA nurses will review and approve all initial MFP/HCBS care plans and will communicate these activities quarterly to DMMA through a report to the Quality Initiative Improvement (QII) Task Force.
DMMA will review reports and follow up, as needed. DMMA will review a sample of MFP care plans annually. The care plan review will consist of a desk audit of case files to ensure completion in accordance with all applicable policies and procedures.

b. Monitoring Safeguards. Select one:

☒	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

The Division of Medicaid & Medical Assistance oversees the administration of all HCBS Waivers and 1115 Waivers and ensures that each Waiver program is in compliance with the Freedom of Choice requirement.

Each of the HCBS Waivers contains elements of self-direction including a person-centered planning process and informed choice of providers. The Waiver consumer, with input from his/her guardian (if applicable), may choose any willing and qualified provider(s), receive information about providers; and meet, interview and select the provider(s). The services outlined in the individual's service plan are tailored specifically to the interests, needs, and competencies of each individual. A service plan becomes effective only after receiving individual or legal guardian approval. The MFP/HCSB consumer will self direct areas of service such as, how they need to be lifted/positioned, what works most comfortably for them for ADL assistance, etc.

Through the MFP demonstration, opportunities for self-direction will continue. Transition Coordinators will educate, explain, and offer the option of self-directing services to every MFP participant. The decision to self-direct services can only be made by the individual. The MFP participant will be provided with specific procedures for voluntary or involuntary switches from self direction to provider-managed delivery systems. This information will include self direction goals and decision making authority. If at any time the participant decided to switch from a self directed approach of services to a provider managed delivery system the transition will appear seamless to the individual receiving services.

Transition Coordinators will also apply principles of self-direction to the use of demonstration and waiver transition services by assuring that participants select qualified services of their choosing. In addition, the Centers for Independent Living (CILs) will be involved in assuring that a person-centered planning process is followed in its role as peer advocates.

The MFP Program Director & assigned MFP staff will be responsible for tracking & monitoring the number of MFP participants choosing self direction.

Delaware values self-direction and options for expanding the participant direction in the waivers will be explored through the MFP Steering Committee and the unique composition of the Stakeholders that include various Divisions' Advisory Councils as well as the Governor's Council. Three HCBS waivers were combined into one effective December 31, 2010 and personal care services were added with a self directed component .
MFP Transition Coordinators will perform outreach, education, transition assessment and assistance for institutionalized residents interested in transitioning to the home and community. Transition Coordinators will provide participants with information regarding consumer rights, including the right to: select a provider; choose a preferred living arrangement and geographic area in which to reside; be actively involved in the transition process; be informed of challenges that may arise during the process; and provide input into the direction of the transition process. If participants choose to receive the MFP personal care assistance demonstration service, they will be able to hire and direct their own assistant. Transition Coordinators will also perform resource and service coordination, transition assistance and post-transition monitoring. The Transition Coordinators are state employees

hired by DMMA.

The Centers for Independent Living are involved in performing outreach workshops regarding the Finding A Way Home program iConsumers may also receive access through the Division of Medicaid & Medical Assistance Long Term Care Eligibility units where an individual can apply for Medicaid. In addition, access may arise through identification or referral from a variety of existing providers and resources, including: institutions and facilities such as hospitals, nursing facilities, and a variety of medical, developmental disabilities, behavioral health, mental health and elderly care providers. These include Community Mental Health Centers, medical providers, public and private agencies, private providers, and home health care agencies.
MFP participants will have access to assistance and supports in a variety of ways. As demonstration participants are utilizing the existing waiver programs for community-based services and support, the current systems for consumer supports that are approved and in place under these waiver programs will be used by the demonstration participants as well. Waiver case managers work with participants to identify the demographics of their emergency/back-up plan in their person center plan for all direct services including transportation, DME and supportive services. Back up plans include a description of the risks faced when emergencies, such as lack of staff, arises. The back up plan also identifies what must be done to prevent risks to health and safety: how people should respond when an emergency occurs, and who should be contacted and when. Back up plans must list individuals who will provide support when regular staff is not available. Back up plans will address 24-7 coverage including the need for 911 for true medical emergencies.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. Select one:

○	Participant – Employer Authority. As specified in Appendix E-2, Item a, the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	Participant – Budget Authority. As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
☒	Both Authorities. The demonstration provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

☒	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
☒	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.

☒	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

☒	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. Specify the criteria:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Prior to entering the MFP program to allow time for the participant to weigh the pros and cons of participate direction, DMMA staff, the transition coordinator, & case manager are responsible for informing participants of their responsibilities, and potential liabilities. DHSS operations staff informs participants at initial eligibility and the contracting entity informs the individual at revaluation as part of service plan development. Participants are allowed time to weigh the pros & cons of participant direction and informed they may access provider managed services at any time.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative (select one):

○	The State does not provide for the direction of demonstration services by a representative.	
○	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (check each that applies):	
	☒	Demonstration services may be directed by a legal representative of the participant.
	☐	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each demonstration service. (Check the opportunity or opportunities available for each service):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Personal Assistant Services	☒	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. Select one:

☒	Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i). Specify whether governmental and/or private entities furnish these services. Check each that applies:	
	☐	Governmental entities
	☑	Private entities
☐	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. Select one:

☑	FMS are covered as a Demonstration service		Fill out i. through iv. below:
○	FMS are provided as an administrative activity. Fill out i. through iv. below:		
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:	
		FMS is incorporated into the MFP demonstration service of Personal Assistant services. A request for proposal has been issued for this service and providers are in the process of being selected. **The costs of financial management services are claimed at the administrative claiming rates. Participants are directed to receive the service from contracting entities fiscal agent or support broker. This entity provides employer and payroll activities to the participant as well as recording and tracking expenditures.**	
	ii.	Payment for FMS. Specify how FMS entities are compensated for the activities that they perform:	
	iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide (check each that applies):	

	Supports furnished when the participant is the employer of direct support workers:	
	☒	Assist participant in verifying support worker citizenship status
	☒	Collect and process timesheets of support workers
	☒	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☐	Other (specify):
	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's self-directed budget
	☒	Track and report participant funds, disbursements and the balance of participant funds
	☒	Process and pay invoices for goods and services approved in the service plan
	☒	Provide participant with periodic reports of expenditures and the status of the self-directed budget
	☐	Other services and supports (specify):
	Additional functions/activities:	
	☒ ☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Other (specify):
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

☐	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:

☐	Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:
☒	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

k. Independent Advocacy (select one).

☐	Yes. Independent advocacy is available to participants who direct their services. Describe the nature of this independent advocacy and how participants may access this advocacy:
☒	No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

This demonstration is designed to allow for participant direction or an alternate service delivery system. The individual notifies the Case Manager assigned to the case that they want provider managed services. The Case Manager will assist the consumer with receiving services through the provider managed system. The individual service continuity will stay intact until provider managed services are intact.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participant direction is terminated when the participant no longer wishes to utilize this type of service or when the participant can no longer manage this type of service safely. The service provider is required to make reasonable efforts to resolve issues before terminating self-direction. This includes conferring with the MFP Transition Coordinator and MFP Project Director to resolve problems that threaten the participant's ability to self-direct his/her services. Examples of situations that may result in involuntary termination of participant direction include:

- The consumer needs a level of service that is beyond the scope and purpose of the Personal Assistance Service**;**

- The consumer's uncooperative behavior, abuse, misuse of the service:
- The unsafe and/or unsanitary conditions or activities in the consumer's place of residence, even though services are provided and listed in the ISP, jeopardizes the safety or health of Assistant(s) and/or the provider agency's staff;
- The involvement of the consumer in illegal activities.

Continued services are in place until a more appropriate service venue is established. The participant is advised by the case manager of the opportunity of a fair hearing.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
FY 2007	0	
FY 2008	1	
FY 2009	12	
FY 2010	17	
FY 2011	24	

Participant Employer

a. Participant – Employer Authority (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

i. Participant Employer Status. Specify the participant's employer status under the demonstration. Check each that applies:

☐	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
☒	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

☒	Recruit staff
☒	Refer staff to agency for hiring (co-employer)
☒	Select staff from worker registry
☒	Hire staff (common law employer)
☒	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The Personal Assistance service provider is required to conduct criminal background checks on all Personal Assistants.
☐	Specify additional staff qualifications based on participant needs and preferences
☒	Determine staff duties consistent with the service specifications
☐	Determine staff wages and benefits subject to applicable State limits
☒	Schedule staff
☒	Orient and instruct staff in duties
☒	Supervise staff
☒	Evaluate staff performance
☒	Verify time worked by staff and approve time sheets
☒	Discharge staff (common law employer)
☒	Discharge staff from providing services (co-employer)
☐	Other (specify):

b. Participant – Budget Authority (Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications
☐	Specify how services are provided,
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for demonstration goods and services
☐	Review and approve provider invoices for services rendered
☐	Other (specify):

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. Select one:

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
☐	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F. Medical Plan of Care

A. Client Name: _____ Case Manager: _____
B. LEVEL OF CARE: LOC_____ d/t_____

INSURANCE: Medicare: yes____ no ____N umber _____ Private Insurance_____

RECOMMENDED SKILLED SERVICES to be rendered in the home:

Skilled Nursing: _____ (Agency) Insurance Payer: _____

Skilled Assessment and Observation r/t_____
(cite medical diagnoses or reasons requiring SN)
Wound Care of : _____ Catheter Care: _____

Other: _____ Visit Frequency: _____

Therapies: _____ (Agency) Insurance Payer: _____

Type of Therapy: PT_____ OT _____ ST _____

Home Health Aide Services (not billed to Waiver):
_____hrs for _____times a week. Agency: _____Payer: _____

Personal Care Services: _____(agency)
Mon-Fri. AM Hours: _____(specify preferred days)
Mon.-Fri. PM Hours: _____(specify preferred days)
Other Hours : _____(specify preferred days)
Week-end Hours: _____(specify preferred days)
TOTAL: _____
Emergency Response System: _____(Agency)
Adult Day Care: _____ Specify days of attendance: _____
Respite: _____

NON-WAIVER SERVICES:
DAST _____
Assistant Services_____
Dialysis: _____
Location: _____
Meals on Wheels _____
Other:_____

A. **Equipment:** **H=Has N=Needs** **Supplies:**

_____
_____
_____
_____
_____

Are client's needs addressed through developed
Plan of care? Yes_____ No _____

Care Plan developed with: _____ Date: _____

RN Signature: _____ CC to CM on: _____

☐ Care Plan amended on: _____ By _____ CC to CM on: _____

Appendix G. Types of Supported Housing

Type of Qualified Residence	# of Each Type of Qualified Residences	State Definition of Housing Settings & # of Each	# of Each Settings	How Regulated
Home owned or leased by individual or individual's family member		• Home leased by the individual or family • Home owned by the individual • Home owned by the family		• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing & cooking areas over which the individual or individual's family has domain & control.		• Apartment building • Public housing units		• Lease with landlord • Public housing agency
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside		• Adult foster care • Group home		• State/agency licensing regs State/agency licensing regs

Appendix H. Summary of Medicaid HCBS Waivers

Waiver	Type	Targeted Population	Income and Resource Limits	Benefits	Case Management	Other
DD(via DDDS)	1915(c)	DDDS clients (ABD or SSI) with Mental Retardation who need intermediate LOC and who can live in the community with supportive services	Same as above.	Regular Medicaid Plan Plus: Habilitation Services Prevocational Services Supported Employment Services Day Habilitation Services Respite Services	Yes; ; Case Manager helps with identifying and obtaining services necessary for client to remain in community safely.	Same as above.

Appendix I. Waiver Quality Management System Template

Note: please see notes and acronyms at the end of this section prior to reviewing this document.

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
HCBS Quality Framework Focus: • **Participant Access**				
An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future	• Conduct Comprehensive assessment and determine LOC on each applicant at initial referral. • Review of LOC determination for accurate application and completeness of LOC criteria. • Review of client record	• DMMA • DDDS • DSAMH • MCO staff	• Review of assessments and LOC determinations. • Retrospective audit of assessments and client records.	• Daily. • Quarterly
Enrolled participants are reevaluated at least annually or as specified in the approved waiver	• Conduct Comprehensive assessment and re-determine LOC on each applicant at least annually. • Review of LOC determination for accurate application and completeness of LOC criteria. • Review of client record.	• DMMA • DDDS • MCO staff	• Retrospective audit of sampled assessments and client records. • Electronic Data Report.	• Daily. • Quarterly • Annually
The process and instruments described in the approved waiver are applied to determine LOC	• Review of client record.	• • DMMA • DDDS • MCO staff	• Retrospective audit of sampled assessments and client records.	• Monthly
The state monitors LOC decisions and takes action to address inappropriate level of care determinations	• Review of LOC determination for accurate application and completeness of LOC criteria. • Review of client record.	• • DMMA • DDDS • MCO staff	• Retrospective audit of all clients who have been denied a LOC. • Retrospective audit of reasons for withdrawal and sampling of those records.	• Quarterly • Annually

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
	• Review of records of clients who have been denied a LOC or withdrew from the program. • Review of state hearing data.		• Retrospective review of state hearing data.	• Annually
• **Participant-Centered Service Planning and Delivery** • **Participant Rights and Responsibilities** • **Participant Outcomes and Satisfaction**				
Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means	• Review service plans for completeness • DMMA review	• MFP CM staff/DDDS staff/DSAMH • DMMA • MCO staff	• Service plans in case files • Service plans in case files	• Ongoing • Annually
State monitors plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of Service Plans.	• Supervisory/peer review of service plans • DMMA service plan review	• /DDDS/DMMA supervisors/staff • DMMA/ MFP staff	• Supervisory review tool • Service plan review tool	• Ongoing • Ongoing
Service Plans are updated/revised when warranted by changes in the waiver/MFP participant's needs.	• Case/manager updates service plan after hospitalization/nursing home stay or major health change • DMMA reviews service plan update	• MCO Case Manager/Nurse •DMMA /DDDS MFP/Waiver staff	• case file • /DMMA/DDDS case file	• Ongoing • Ongoing
Services are delivered in the type, scope, amount, duration, and frequency and are delivered in accordance with	• Case manager/nurse contact service plan monitoring review • DMMA service plan	• MCO case manager/nurse • DDDS • DSAMH	• service plan monitoring tool • Service plan monitoring	• Quarterly • Quarterly

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
the Service Plan.	monitoring review	• DMMA(EQRO)	tool	
• **Provider Capacity and Capabilities**				
State monitors non-licensed/non-certified providers to assure adherence to waiver requirements	Currently there are no non-licensed/non certified providers enrolled in Waiver programs. MFP providers may be non –licensed/non certified	Currently there are no non-licensed/non certified providers enrolled in Waiver programs MFP program review staff	Currently there are no non-licensed/non certified providers enrolled in Waiver programs Tool will be developed or tool used for certified providers will de used until development	Currently there are no non-licensed/non certified providers enrolled in Waiver programs Annually
State verifies on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards	• Annual site visit survey of facilities • Review provider certification • Review provider capacity • Results from complaint monitoring, on-site surveys, and provider and client satisfaction surveys are summarized and analyzed for trends	• DPH • DDDS	• DPH annual site visit survey instrument and reporting • DDDS Quality Unit • Data and tracking analysis	• Annual • Quarterly and on as needed basis • Quarterly
State identifies and rectifies situations where providers do not meet requirements	• Provider relations agent monitors CMS records for fraud and abuse	• DMMA/ Provider Relations Agent • DDDS Contracting Staff •	• Audits • Audits	• Annual and on as needed basis
State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver & MFP	• Provider staff possess appropriate skills, competencies, and certification • All providers have an emergency preparedness	• DPH • waiver & MCO MFP staff • DDDS waiver staff • DMMA MFP staff • DSAMH	• DPH annual site visit survey instrument and reporting • Case Management Provider Monitoring Reports	• Annual • Annual and on as needed basis

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
program	plan			
• **Participant Safeguards** • **Participant Outcomes and Satisfaction**				
There is continuous monitoring of the health and welfare of waiver & MFP participants and remediation actions are initiated when appropriate.	• Annual site visit survey of facilities • Review of care plans • Review provider certification • Review provider capacity • Documentation of medication regimen (when applicable) • Staff certification • Results from complaint monitoring, on-site surveys, and provider and client satisfaction surveys are summarized and analyzed for trends.	• DPH • waiver & MFP staff • DDDS waiver staff • DMMA MFP staff	• DPH annual site visit survey instrument and reporting • Case Management and Provider Monitoring Reports • Client satisfaction surveys conducted by administering agency • Data and tracking analysis	• Annual • Annual and on as needed basis • Annually
State, on an on-going basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation	• Participant has access to for reporting incidents • Participant is presented with information at admission about provider services, and participant rights • Analyze incident data and report to QII and QIC	• DPH • • DDDS Quality Unit • MFP staff • DSAMH	• Survey instrument and reports • Case Management and Provider Monitoring Reports • Participant records	• Annual and on as needed basis
Assurance: H.1.e.: Administrative Authority **HCBS Quality Framework Focus:** • **System Performance**				
Medicaid Agency or operating agency conducts routine, on-going oversight of the waiver & MFP program	• SUR peer ranking of all providers • LOC and Service Plan audits	• DMMA MFP Staff • DMMA MFP Staff • DMMA MFP Staff • MFP Staff	• SUR subsystem • Client records at DSAAPD/DDDS offices • Monitoring and reporting	• Quarterly • Annually • Monthly and

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
	• DMMA QII (Quality Initiatives Improvement Task Force) Monitoring and Reporting • DSAAPD/DDDS/DMMA QIC (Quality Improvement Committee) Monitoring and Reporting	• DDDS	to DMMA Leadership and Managed Care Advisory Committee • Monitoring and monthly reports	Quarterly • Monthly
• **System Performance**				
State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver & MFP program.	• MMIS financial and utilization reporting • SUR peer ranking of all providers • Claims Processing	• DMMA • DMMA • DDDS fiscal staff	• MMIS management reports • SUR subsystem and provider audits • MMIS – Claims • Form 64 • 372 Reports	• Monthly • Monthly • Monthly • Annually

Notes

- DMMA contracts with the provider relations agent to provide MMIS system and reporting technical support.

Acronyms

- DMMA – Division of Medicaid and Medical Assistance
- DDDS – Division of Developmental Disabilities
- DSAMH- Division of Substance Abuse & Mental Health
- EQRO- External Quality Review Organization
- QII – Quality Initiative Improvement Committee: Medicaid's Quality Management System strategy development and ongoing infrastructure for ensuring oversight and integration of the waivers' quality strategy with Medicaid's overall strategy.
- QIC – Quality Improvement Committee: DMMA/DDDS/DSAAPD's quality committee responsible for the division's quality management strategy for all of the waivers operated within the division.
- QIC – Quality Improvement Committee: DMMA/DDDS/DSAAPD's quality committee responsible for the division's quality management strategy for all of the waivers operated within the division.

SEE BROCHURE CHANGE SEE WITH AMENDMENT VIA Email to CMS

Appendix K. Winter 2005 "On My Own" Workshops (see updated workshops sent to CMS under separate email)

Appendix K

IRI "ON MY OWN" WORKSHOP SERIES

"On My Own" is a series of workshops designed to empower and inform those individuals with disabilities who have expressed interest in making a personal transition from an institution of care to an independent mode of life in which they can assume control and take responsibility for their own lives.

Each workshop will consist of an ice-breaker activity during which a gift will be presented to a participant. Lunch will be served as an incentive for attendance. All participants will be encouraged to express their opinions in each workshop. Use of the DART Para transit system will be highly encouraged.

Following are synopses of eleven (11) workshops to be presented by Independent Resources, Inc. Each topic is designed to provide practical information to individuals as they plan and secure various services to facilitate community living. As persons with disabilities learn to assume control of their lives, IRI serves as a center of information and assistance for such persons. The workshop series is one element in a broad program of services at IRI.

These workshops are designed and conducted with the ***MFP client*** in mind. The series began in April 2011 and will conclude in September 2011. It will then resume in November 2011 and run through May 2012.

Please refer to the following pages for workshop topics and a synopsis.

SYNOPSIS

INTRODUCTORY WORKSHOP

This workshop is designed to provide a comfortable and informal setting in which participants will have a chance to acquaint them with each other and to share personal experiences and aspirations.

The purpose of the workshop series will be discussed with emphasis on building self-esteem essential to a successful transition to independent living.

CIRCLE OF CARE AND SUPPORT

This workshop will focus on ways to build and expand a personal support system. Current individual support and care will be discussed, such as family, friends, and professional associates. Attention will also be given to the importance of personal responsibility and the meaning of "You are the center of your own care."

FINANCIAL MANAGEMENT

This workshop will emphasize the importance of money management in the transition process. The discussion will include budgeting, opening and maintaining an account, bill paying, managing expenses, and other essential information. Focus will also be given to current monetary habits and new expenses incurred upon transition.

HOUSING OPTIONS

This workshop will promote a discussion of various housing options, their costs, and factors to consider in choosing a residence. Attention will also be given to resources which consumers can contact for information. Tips for setting and using personal search criteria will be provided. The objective of this workshop is to enable the individual to find and secure independent living arrangements which best suit their needs and preferences.

BE YOUR OWN LEADER

The goal of this workshop is to empower individuals with disabilities to assume and maintain charge of their lives. To accomplish this objective, personal responsibility, positive action, and persistence will be discussed. It will also be stressed that these attributes are essential to independent living and self-fulfillment.

TRANSPORTATION

The purpose of this workshop is to provide information about transportation options for people with disabilities. Most of the time allotted will be directed to a discussion of the DART Para transit system, including recent proposed changes. Tips will be offered on how to use DART, and participants will have an opportunity to talk about their experiences using the system.

EMERGENCY PREPAREDNESS

This workshop will emphasize the importance of personal preparation and readiness for an emergency ranging from a sudden personal illness or injury to an area-wide disaster. Discussion will include a basic inventory of items to keep on hand and steps which the individual should take to maintain sufficient control of the situation. Specific examples of emergencies and effective reactions will be presented, and participants will be asked to discuss how they would respond.

MAKING THE RIGHT DECISION

This workshop will offer instruction on techniques which can be used to make a correct and confident decision. The process of gathering and weighing various data and evaluation of personal criteria and circumstances will be explained, all of which are critical considerations. Specific instances in which an important decision is required will be discussed, as well as potential consequences of making a wrong one. Using knowledge gained from past mistakes will be emphasized as a useful tool in decision making. Participants will be invited to talk about personal experiences in reaching decisions.

A NEW BEGINNING

This workshop will be devoted to the happy prospect of an individual's start to a new life of independence in which he or she anticipates being part of a community of personal choice. Options for personal involvement in community activities will be suggested as well as ways to establish one's social footing in the community. Educational and recreational opportunities will be presented as a means to attain personal satisfaction. Discussion will be given to how to address and voice concern about any problems in a personal support system which is vital to maintaining independence.

BENEFITS

The purpose of this workshop is to offer instruction regarding the acquisition and/or management of various benefits, medical and otherwise, which are crucial to the welfare of an individual after leaving an institution of care. Risk of loss of some benefits relevant to personal assets, e.g. income from employment, will also be explained.

SUBSTANCE ABUSE

This workshop will emphasize personal responsibility as it relates to substance abuse, particularly in light of the new freedom which the individual will embrace upon moving to the community. Participants will be informed of various programs designed to prevent or intercept substance abuse. They will be encouraged to honestly consider personal tendencies and habits which might be detrimental to successful community living. Personal consequences and potential health problems will be discussed as well as the urgency of seeking help when undesirable behavior occurs.

PAYMENT SCHEDULE

Independent Resources will provide On MY Own workshops to Approved MFP Recipients and will send itemized invoices at least quarterly for payment and will be reimbursed for those workshops as follows once a person has completed all of their classes:

1. Orientation and 1 class and does not return — $200
2. All other classes and workshops — $100 each (not to exceed a total of $1,996 for all classes or workshops)

Delaware Health and Social Services
Division of Developmental Disabilities Services (DDDS)
Quality Management System

(Updated September 6, 2007)

Table of Contents

List of Appendices

List of Tables

List of Figures

SECTION I: INTRODUCTION TO DDDS QUALITY MANAGEMENT

Definition of Quality Management: systemic data collection to improve the quality of services and supports.

Quality Management (QM) is a crucial operational feature used by an organization to determine whether it operates in accordance with approved program designs, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies improvement opportunities. The Division of Developmental Disabilities Services (DDDS) is committed to the development and ongoing evaluation of a QM System designed to use information for decision-making at all levels throughout the system. The DDDS recognizes that quality is no longer the purview of just one entity, such as the "Quality" Department. Everyone has some role or responsibility regarding quality; quality is everyone's business.

Consequently, the DDDS collects, analyzes and trends data from a variety of sources relative to performance indicators identified by consumers, stakeholders and administrative authorities, with the aim of effecting improvements in its service delivery system.

Services and supports currently incorporated into the QM System include contracted agency-managed residential and day services, State-operated day programs and shared living services – most of which are funded under the HCBS Waiver. The state's ICF/MR, Stockley Center, has also been partially integrated into the system (i.e., included when there are existing survey tools/processes that address both Community Services and Stockley). Future plans include more fully integrating Stockley Center into the QM System as well as Family Support Services (should DDDS apply for a new waiver for these services). State funded respite care services are also included in the QM System.

The purpose of the DDDS QM System is to:

- Increase involvement of individuals and families
- Result in service improvement for individuals and providers of support
- Support choice and control by individuals and families
- Be dynamic and flexible
- Be based on the premise of collaboration
- Make information about the quality of services and supports readily available to individuals and families and provided in a format that is easy to understand
- Monitor basic assurances, such as the health and welfare of individuals receiving services, the adequacy of the Plans of Care (Essential Lifestyle Plans or ELPs), and provider qualifications

The following sections demonstrate how the DDDS QM System uses outcomes and indicators to measure quality, the processes of discovery or sources of information used to measure performance, remediation and improvement, and key roles and responsibilities for managing quality.

SECTION II: DDDS QUALITY MANAGEMENT OUTCOMES AND INDICATORS

In the fall of 2005 DDDS developed a series of performance outcomes and corresponding measurement indicators. Through meetings and/or focus groups input was solicited from providers of support, family members, individuals receiving services, DDDS staff and administration, and members of the Quality Assurance and Improvement (QA/I) Grant Stakeholders Committee. In keeping with the mission of DDDS, many of the outcomes developed focus on choice, quality of life, and meaningful participation in one's community. Following are the DDDS outcomes listed according to area of concern. (A complete list of outcomes and indicators is located in ***Appendix A***.)

Definition of Outcome: the end result we want to achieve for people through the systems that support them

Definition of Indicator: statements that express how you would know if an outcome is present

Table 1: DDDS Outcomes

Area of Concern: Freedom from Harm ▪ People are free from serious injuries and accidents ▪ People have a safe transportation system ▪ People live and work in safe environments ▪ People receive the correct medications	Area of Concern: Choice ▪ People make choices about their lives. ▪ People make choices about where and with whom they live ▪ People make choices about how they spend their money
Area of Concern: Health and Wellness ▪ People receive preventative health care ▪ People have access to health care services and supports ▪ People have access to mental health services ▪ The use of psychotropic medications is monitored ▪ People are supported to have good nutrition ▪ People are assisted with their personal care	Area of Concern: Access to Services and Supports ▪ People have access to community based services and supports
Area of Concern: Relationships and Community Membership ▪ People are connected with their family ▪ People have friends and relationships ▪ People participate in community life	Area of Concern: Individual Planning and Implementation ▪ People's plans reflect their needs and preferences ▪ People's plans are implemented ▪ People are supported to communicate
Area of Concern: Community-Based Employment ▪ People have jobs that meet their preferences and support needs ▪ People feel welcomed in their workplace ▪ People receive commensurate wages and benefits ▪ People are supported to be employed	Area of Concern: Staff Stability and Competency ▪ Staff and case managers are competent and have received training to support individuals ▪ Staff are respected and adequately compensated for their work
Area of Concern: Accommodations ▪ People have supportive devices and equipment that they need ▪ People's supportive devices and equipment are safe	Area of Concern: Qualified Providers ▪ DDDS providers are qualified to support individuals

Area of Concern: Rights and Respect	Area of Concern: Systems Performance
▪ People exercise their rights ▪ People are respected ▪ People are free from unnecessary restraints and other restrictive procedures ▪ People's funds are protected ▪ People have access to their money	▪ The system supports people to live in the most integrated setting possible ▪ The system is financially accountable

From the complete list, specific outcomes and indicators were prioritized for initial QM development by the QA/I Grant Stakeholder Committee, DDDS Executive Staff and the Performance Analysis Committee (PAC). (This committee is described in more detail in Section IV.) Initial emphasis was given to addressing CMS assurances and utilizing existing survey tools and databases. The list of prioritized outcomes and indicators is displayed in ***Appendix B.***

Review and Modification of the Quality Management Outcomes and Indicators

The Quality Management outcomes and indicators identified by the various parties represent a starting point for the collection and reporting of data to measure the quality of services DDDS provides. These initial indicators are intended to be modified over time as the service system changes. Future modifications may be based on:

- Recommendations of the various quality-related review committees (Risk Management, Mortality Review, Executive Staff, Quality Council, etc.[1]) that receive PAC quality management reports;
- PAC recommendations to expand reported-on indicators;
- Identification of new or revised level of priorities by DDDS/DHSS administration;
- New data collection and analysis technology implemented by DDDS;
- New issues that become important to individuals, families and other advisory committees;
- Refinement in the success criteria of indicators will change based on findings and subsequent reports.

As indicators are expanded, new discovery processes may be developed or new survey elements added to existing instruments under the purview of the Performance Analysis Committee. Often databases will need modification to enable the tracking and analysis of the information for each new indicator.

SECTION III: PROCESSES FOR DISCOVERY AND REMEDIATION

The discovery portion of the Division's Quality Management System relies on the survey processes conducted by nearly everyone at DDDS. These oversight functions have been built into, and are an integral part of, their job duties. As Table 2 displays, the majority of different surveys involving remediation and verification activities are done by staff of the division's Office of Quality Management, and several are done by DDDS nurse consultants and case managers. In addition, there is oversight involvement by family monitoring groups,

Definition of Discovery: methods and processes to monitor the quality of the service system.

Definition of Remediation: actions taken to fix problems on an individual and provider level

[1] These committees are described in more detail in Section V

formal review committees, other DDDS staff or disciplines, and by the day and residential service providers. The Division's sister agency – Delaware Health and Social Services, the Division of Long Term Care Residents Protection – also plays an important role in the licensing of community homes. Table 2 displays the various quality management discovery processes used for ongoing monitoring on an individual and provider level. Many of the processes are also used as data sources to measure the DDDS outcomes and indicators.

Table 2: DDDS Discovery Processes
(Refer to ***Appendices H - V*** for policies and procedures related to these processes)

Discovery Process	Responsible Entity	Frequency	Data Source	Party Responsible for Remediation	Unit Responsible for Verifying Corrections
Incident reporting process	Any DDDS Staff or Provider	As Occurs	TherapServices database	Day or residential provider	DDDS ELP Team M-embers
PM-46 reporting	Any DDDS Staff or Provider	As Occurs	PM-46 tracking.xls	Day or Residential, Shared Living providers or internal DDDS staff	DDDS case manager for day/residential agencies OQM for Shared Living
PM-46 investigations	PM-46 Coordinators, OQM and LTCRP	As Occurs	PM-46 Follow-up. MDB	Day or Residential, Shared Living providers or internal DDDS staff	DDDS case manager for day/residential agencies OQM for Shared Living
Case Manager Monthly Home visits	DDDS CM	Monthly	CM Monthly Home Visit ID Note.xls (separate files in each region)	Residential agency or Shared Living provider	DDDS CM
Case Manager Day Program visits	DDDS CM	Quarterly	None	Day program or residential provider, others, as appropriate	DDDS CM
Review & audits of Personal Spending Records (PSR)	DDDS CM	Monthly	None	Residential agency or Shared Living provider	DDDS CM
Nursing Monthly home visits	DDDS Nurse Consultants	Monthly	Monthly Medication and Health Audit.xls	Residential provider agency	DDDS Nurse Consultants

Discovery Process	Responsible Entity	Frequency	Data Source	Party Responsible for Remediation	Unit Responsible for Verifying Corrections
Adult Special Populations (ASP) Parent Monitoring	Families of people served in the ASP Program	Annually	None	Day program or residential provider; as appropriate	Families of people served in the ASP Program / Director ASP Program
Mortality Review Process	DDDS contracted nurse	As Deaths occur in Residential Services	Mortality Data.xls	Varies according to circumstances	Health Services Director/MRRC Chairperson
Community Living Arrangement (CLA) certification process[2]	OQM	Annually	CLA Certification process (DB to be developed) ELP-HCB Waiver Material Completion.xls	Residential provider agency	OQM
Day Program certification process	OQM	Annually	DP Survey Results.xls	Day program director	OQM
ELP, Self-Determination & Satisfaction Reviews	OQM (for residential services and Stockley Center	Annually (per site)	ELP SD&S Scores.xls	Residential provider or Stockley	OQM (Response Tracking)
COR/ELP Review survey	OQM for Residential and Shared Living	Annually	COR/ELP Excel Databases for each region	DDDS Case Managers	Regional Program Directors
Neighborhood Home certification[3] and licensure process	OQM/ LTCRP	Annually	DDDS NGH regulations Results.xls ELP-HCB Waiver Material Completion.xls	Residential provider agency	OQM/Long term Care Residents Protection (LTCRP)
Shared Living Contract review	Shared Living Unit (new procedure)	Annually	County Compliance Plan Tracking.xls	Shared Living provider	DDDS CM
Shared Living licensure (for homes serving more than one adult)	LTCRP	Annually	County Compliance Plan Tracking.xls	Shared Living provider	LTCRP

[2] OQM CLA certification includes a COR/ELP Record and ELP-HCB Waiver Material Reviews

[3] OQM NGH certification includes a COR/ELP Record and ELP-HCB Waiver Material Reviews

Discovery Process	Responsible Entity	Frequency	Data Source	Party Responsible for Remediation	Unit Responsible for Verifying Corrections
DDDS Appeals process	Appeals Committee	As Occurs	DDDS Appeals.xls	N/A	N/A
OBCBS[4] Tracking System	OBCBS	Ongoing	OBCBS tracking database	OBDBS	OBCBS
Tracking of staff training completion	Training Department (TAPD)	Ongoing	Train Track Access Database (will convert to TherapServices database	Day or residential provider	Director of TAPD; OQM

The frequency at which the various discovery processes are employed range from an as needed basis (e.g., incident investigations, placement tracking or mortality reviews) to an annual basis (e.g., certification or licensure of the service provider). More frequently, however, are the routine monthly or quarterly day program and home visits made by the DDDS case managers and nurse consultants. These two professional disciplines have the vital, first-line responsibility for monitoring and ensuring the adequacy of services.

The scope of these various reviews include the people who receive services from DDDS, the sites where they are provided day or residential services, the providers of those services and the service system itself. The discovery methods employed involve a number of different processes. Visits to where people live or receive daytime services play an important part in monitoring as do observations and interviews with individuals served and those who provide services. These interviews become important when investigating unusual incidents or reports of abuse, neglect, mistreatment, financial exploitation or significant injury, sometimes with involvement from Long Term Care or law enforcement authorities.

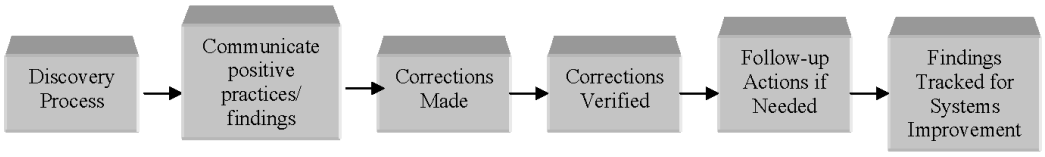
A central discovery method used by DDDS professional staff involves a review of the active record of the person surveyed. Information gathered during the record review includes, among a number of other critical elements: comprehensiveness of the services provided and the timely completion of various assessments, HCB Waiver related documents, plans of care, and health-related appointments.

Monitoring the service providers' compliance to established policy standards and formal regulations is an ongoing function of DDDS nurses and case managers in their routine monthly or quarterly site visits, as well as the principal duty of the Office of Quality Management (OQM) and Long Term Care staff in their annual certification and licensure surveys. The oversight of the managing of peoples' financial resources, especially with regard to their monthly spending money, is primarily a DDDS case management duty with annual cross-checks done by the OQM Program Evaluators. This oversight takes the form of reviewing expenditures for appropriateness, checking the accuracy of spending records and doing actual audits of funds on hand in the homes.

[4] OCBCS refers to the DDDS Office of Budget, Contract and Business Services

The remediation process leading to improvement in areas found below expectation varies with the survey and discipline involved in the initial discovery process. Generally, the procedure flows as follows:

Figure 1: Procedure of Ongoing Remediation



After the initial survey or collection of information, the findings of the professionals involved in the discovery process are communicated with the providers or others who will be involved in sharing promising practices and taking corrective action when needed. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed up by a written report noting those areas needing correction and a date by when such is to be completed. Sometime later, following the corrections being made by the responsible parties, it is the general practice to follow-up verifying that the corrections have been made and are acceptable. For those surveys done by the Office of Quality Management, verifications usually take the form of an additional look-behind review (refer to Appendices C and D). With other disciplines, corrections may be verified at the time of the next normal review, or through the submission of applicable documentation.

Should the necessary corrections not be performed or still leave room for improvement, further actions are generally taken. This usually begins with communication of the inadequacy of the response and, in some cases, guidance in making the proper corrections. Higher administrative authorities in the organization may be notified of the inadequacy of the response and the possibility of sanctions should improvements not be soon forthcoming. These sanctions may range from the provider being placed on contract probation, the granting of a Provisional License by LTCRP, a freeze on new individuals being placed with the agency, removal of people from the provider's care or, in extreme cases, contract termination. Generally, unless the infractions involve egregious health and safety, rights or criminal violations, much work and effort is made by Division staff to assist the provider to come up to the expected performance before the contract is terminated by the Division.

Finally, with ever increasing frequency, DDDS departments are attempting to track the results of their discovery processes in a variety of databases. This tracking may serve to provide a number of benefits. It may provide a prompt in the remediation process, offer a comparison of results longitudinally or among providers, or be used by the Division in a variety of systems-improvement efforts.

Local Ongoing Monitoring and Remediation

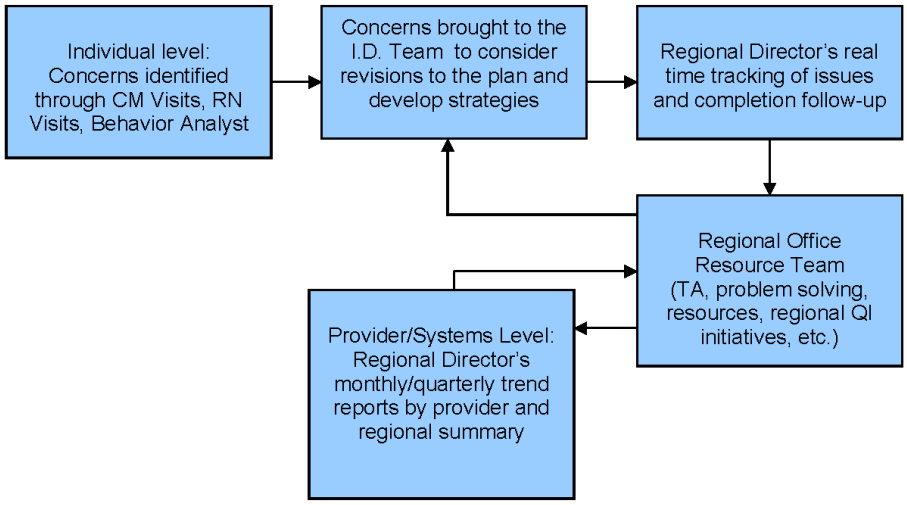
Regional Offices have a key role in ongoing monitoring in order to verify that issues on an individual and provider level have been resolved. Although not yet developed, Regional Directors will have access to "real time" reports that track issues and follow-up along with monthly summary reports from various discovery processes including PM-46/incident reports, case management visits; nursing visits; OQM provider reviews (e.g., shared living, CLA, NGH, day program), etc. Each office will have a Resource Team whose members are responsible for

oversight of family support, case management, day and residential services for all individuals receiving support in the Region. In addition to the Regional Program Director, membership will include a nurse, behavior analyst, case management supervisor, and Office of Quality Management staff. Following are the major Regional Resource Team responsibilities:

- Review unresolved and emerging serious individual concerns and provide technical assistance and/or resources to the Essential Lifestyle Planning (ELP) team
- Review unresolved and emerging provider issues and provide technical assistance, resources, and/or requesting further review, etc.
- Periodically reviewing Regional Office trends and developing local improvement strategies

Following is a graphic representing the unique Regional Office ongoing monitoring role and responsibility:

Figure 2: Local Monitoring Cycle



SECTION IV: MOVING FROM REMEDIATION TO DATA ANALYSIS AND SYSTEM IMPROVEMENT

Definition of Data Source: Information that is used from the discovery processes to measure performance on the DDDS Indicators

The preceding sections describe the various discovery processes and how they are used to identify what is working well and fix or remediate individual or provider level problems on an ongoing basis. This section describes how the discovery processes become "data sources" from which information is collected, aggregated and analyzed to measure the DDDS quality outcomes and indicators. Also described in this section

is how DDDS uses the information on the outcomes and indicators for system wide improvement.

Entities Responsible for Collecting, Aggregating and Analyzing Data

Section III above describes the various discovery processes used to capture important information about quality. As displayed in *Table 2*, everyone has some responsibility for collecting data. Providers, DDDS case managers, Office of Quality Management staff, among others, all gather information about the quality of services and supports and use a variety of processes to report data to DDDS. DDDS staff currently has primary responsibility for entering information and maintaining the various data sources also listed in *Table 2*. Some of these responsibilities will change over time particularly with development of web-based applications that enable providers, case managers and others to enter data directly.

The DDDS Performance Analysis Committee (PAC) is the entity responsible for data compilation, analysis and reporting on the priority outcomes and indicators. Key roles and responsibilities of the PAC are as follows:

- Develop Performance Measurement Specification Worksheets (PMSW), which are used to describe each priority indicator (See ***Appendix E***);
- Ensure ongoing data integrity and reliability;
- Create reports of the data for various stakeholder groups;
- Recommend the creation or revision of information collection tools and data tracking instruments;
- Revise the QM System and/or specific indicators based on stakeholder input;
- Track the system improvement efforts and strategies of the various stakeholder groups so as to assist both in the production of a Division annual report and with necessary federal HCB Waiver quality reports.

The PAC policy and procedure is located in ***Appendix F.***

Types of Reports, Frequency and Dissemination

There are two basic types of quality management reports: reports displaying provider level trends and reports of state-wide trends described as follows:

Provider Level Reports: These reports of trends across providers are disseminated to the providers, Regional Program Directors and Community Services/Adult Population Directors. All work collaboratively to develop and implement improvement strategies. These reports may compare agency results for a better perspective on performance. Some reports may display results on individual sites across agencies to identify areas of strength or weakness with greater specificity.

Systems Level Reports: These trends reports display data about the system as a whole, by region, by service category, etc. Reports are disseminated to various committees to develop and implement improvement strategies. Descriptions of these committees are in Section V below.

Reports are issued semi-annually or annually and, in a few instances, quarterly. More frequent reports are generally tied to indicators concerned with serious health and safety issues where

DDDS might want to proactively track and address trends. A broader range of indicators that might lead to more overarching improvement strategies are covered in the annual report. Distribution of the annual report is also broader and would include posting on the DDDS web site.

In the future, the QM System will enable specific types of data, such as incident and PM-46 data, to be posted on the web. Users will be able to generate tailored reports.

Basic Report Concepts

Reports are designed to maximize understanding and readability by a broad audience. Displays of data are in easily understood language and free of jargon. Reports generally include the following information:

- Indicator that is being measured
- Source(s) of the data (what processes provided the information to measure the indicator)
- Displays of the data
- Analysis of the data
- Description of past improvement strategies and their resultant effectiveness
- Conclusions and actions taken/improvement strategies for the reporting period
- Follow-up actions from the previous reporting period

Confidentiality of personal information is of primary importance in the DDDS Quality Management System.

SECTION V: MOVING FROM DATA ANALYSIS TO CONTINUOUS QUALITY IMPROVEMENT

Following are the various individuals and committees that receive quality management reports and have overall responsibility for reviewing data and developing improvement strategies:

Definition of Quality Improvement: aggregating data/information to identify system wide trends and making continuous improvements in the services and supports.

- Risk Management Committee – An internal administrative committee appointed by the DDDS Director and charged with monitoring organizational risk through the review of key indicator data. They are additionally responsible for developing strategies that address risk management activities.

- Authorized Provider System (APS) Committee – A DDDS Director-appointed committee charged with maintaining the residential and day authorized provider system including holding mandatory provider meetings, reviewing authorized provider applications, updating forms and the APS website and making changes to the system as needed. Developing and monitoring performance-based contract objectives for residential providers is also under the purview of the APS committee. Results of provider performance will be published on the APS website and will be available to individuals and families as they make provider choices.

- Mortality Review Committee – An interagency group whose members include medical and legal professionals, appointed by the Director of DDDS for the purpose of reviewing death

reports and other mortality-related data regarding individuals receiving residential services from the Division so as to identify and recommend system improvements in health care practices.

- Essential Lifestyle Planning (ELP) Oversight Committee – A committee comprised of members both internal and external to DDDS and chaired by the Statewide ELP Coordinator. This committee is charged with the responsibility of reviewing and revising the DDDS ELP User's Manual and serves as the central repository of questions, recommendations, and improvement strategies relative to the ELP.

- Community Services and Adult Special Populations Directors – Two members of DDDS Executive Staff who report directly to the Division Director and who are responsible for the oversight of all services statewide within the Community Services or Adult Special Populations programs.

- Regional Program Directors – Members of DDDS Senior Management who are responsible for the oversight of case management, and clinical services for all of the individuals receiving support in New Castle, Kent, and Sussex Regions. Regional Program Directors report to the Director of Community Services.

- Division of Medicaid and Medical Assistance (DMMA) – The State Medicaid Agency responsible for administrative oversight and authority of HCB Waiver services in Delaware. DMMA routinely reviews reports provided by DDDS on the quality of the developmental disabilities waiver program as a part of their authority as the administering agency for waiver services.

- Quality Council – A volunteer group of approximately 20 interested family members, people served, providers and direct support staff who meet to review quality reports and make recommendations for system improvements. Refer to ***Appendix G - Quality Council draft outline***.

Each of these individuals and committees has specific roles and responsibilities for using the data for developing system wide improvement strategies, and in identifying and promoting promising practices. The first two committees are comprised of "internal" DDDS staff. The Mortality Review Committee and the ELP Oversight Committee are comprised of both "internal" DDDS staff and "external" stakeholders. All of the identified committees routinely review applicable statewide level reports as described above in order to recommend, develop and/or implement system improvements, as their scope of authority permits. In addition, the DDDS Regional Program Directors and the Directors of Community Services and Adult Special Populations routinely review provider level reports and work together to put into operation effective improvement strategies. Information is also disseminated by the DDDS to The Division of Medicaid and Medical Assistance (DMMA) as part of the CMS-required annual Quality Report. Formed in spring 2007, the DDDS Quality Council, comprised of both internal and external stakeholders, serves in an advisory capacity to the Division Director relative to enacting systems improvements across a variety of DDDS services and programs.

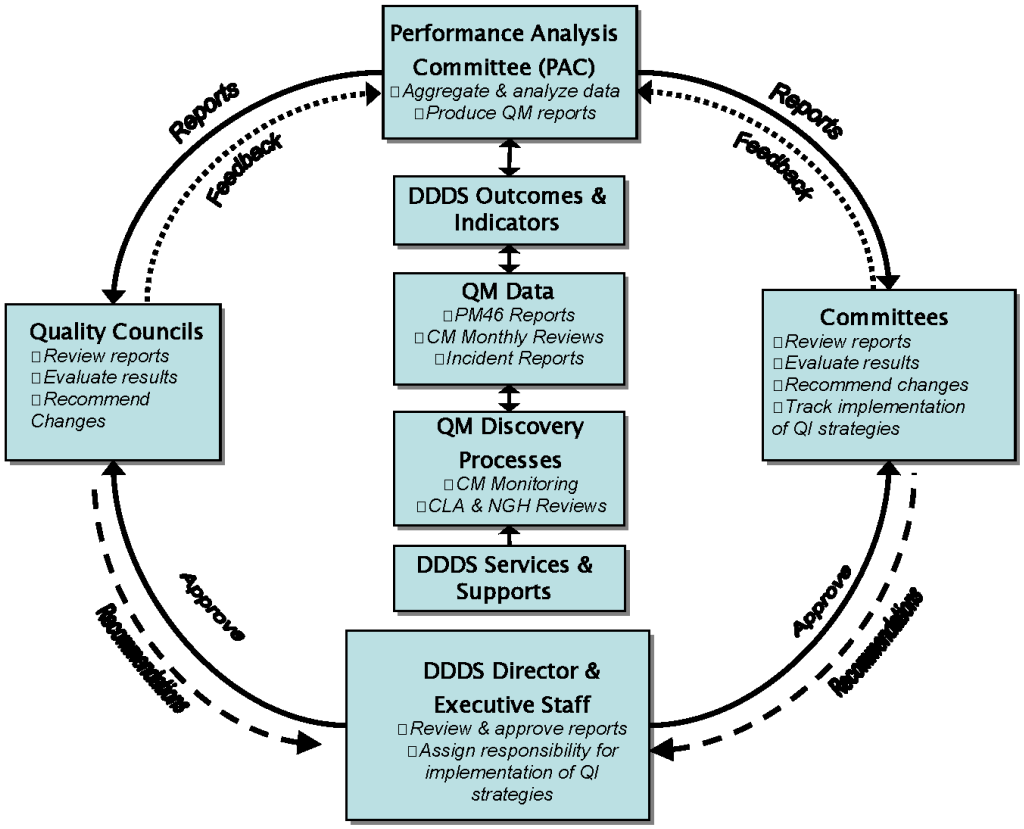
Appendix B displays the priority indicators along with the sources for the information, whether the information is reported on a provider or systems level, how often reports are disseminated, who develops improvement strategies, and finally, who is responsible for ensuring that actions

are completed. A crosswalk of the indicators to the CMS Assurances is also included in the chart.

Figure 3 below displays how the DDDS Quality Management System is built on the premise of continuous quality improvement: Information is generated on the quality indicators; various groups and individuals are responsible for reviewing the information and, where needed, develop strategies to improve services and supports. Once the strategies have been implemented, new reports are generated to see how effective the strategies have been or if there is a need to go back to the drawing board.

Figure 3

Division of Developmental Disabilities Services
Continuous Quality Improvement Cycle



SECTION VI: EVALUATING THE QUALITY MANAGEMENT SYSTEM

Definition of Formative Evaluation: is a method of judging the worth of a program while the program activities are forming or happening. Formative evaluation focuses on the process as opposed to program outcomes.

The ability of the DDDS to collect, analyze and use information to provide internal and external stakeholders with accurate, timely and important information to improve the quality of services and supports is evaluated on an ongoing basis. This type of assessment is called formative evaluation. The Performance Analysis Committee has primary responsibility for evaluating the ability of the discovery processes and data sources to accurately measure the outcomes and indicators and for correcting problems with data collection activities as needed. As well, the PAC solicits ongoing feedback from the various committees that review the QM reports. Committee members are asked to assess the following:

- Was the information timely?
- Was the information helpful in identifying statewide trends?
- Were the reports easy to understand and follow?
- Are the outcomes and indicators meaningful or should they be changed?

SECTION VII: FUTURE DIRECTIONS IN THE DDDS QUALITY MANAGEMENT SYSTEM

DDDS recognizes that the Quality Management System will evolve and change over time. Following are some of the future endeavors being considered to build future improvements:

Current Priorities:

- Revise the OQM Certification system to conduct agency-wide reviews (not by separate locations as is the current process for Neighborhood Group Homes and Day programs or by service type as is the current process for Community living Arrangements
- Complete the Authorized Provider Performance Measures
- Complete revisions to the Case Management Monitoring Process and Tool
- Begin to prepare for the CMS Assurances Evidence Report

Longer Term Improvements:

- Continue to refine the various discovery processes so that they will align with the DDDS outcomes and indicators.

- Continue to aggregate and analyze the data for the indicators that align with the CMS Assurances.

- Publish an annual QM Outcomes and Indicators Report.

- Continue to explore the roles and responsibilities for the various committees that use data to develop improvement strategies (e.g., Risk Management, ELP Oversight, etc.)

APPENDIX A:
DDDS QM SYSTEM COMPLETE OUTCOMES & INDICATORS
June 2007

Outcomes	Indicators
Area of Concern: Freedom from harm	
People are free from serious injuries and accidents	1. The rate of serious injury (reported by types of injury) decreases
	2. The proportion of people who were victims of selected crimes reported to a law enforcement agency by type of crime decreases
	3. The proportion of people who have had substantiated incidents of abuse/neglect/ mistreatment by type decreases
	4. The proportion of provider safety items in compliance reported by category of major safety issue
	5. The mortality rate of people served by DDDS compared to the general population of Delaware, by age and by cause of death (natural or medico-legal)
People have a safe transportation system	6. The proportion of major unusual incidents that occurred while using public transportation (DART or DAST), DDDS fleet, or DDDS contracted
People live and work in safe environments	7. The proportion of people who report they feel safe in their home and neighborhood
	8. The proportion of people who report they feel safe where they work or at their day program
	9. The number of citations providers receive for environmental issues decreases
	10. The incidents of serious injuries at homes and work/day programs decreases
	11. The number of provider citations for inadequate procedures for emergencies and disasters (e.g., fire drills, evacuation plans) decreases
People receive the correct medications	12. The number of reported medication errors (reported by type of error, provider and service) decreases
	13. The proportion of medication errors where required PM-46 (investigation) follow-up was completed
Area of Concern: Health and Wellness	
People receive preventative health care	14. The proportion of people who have routine preventive health screenings (e.g., physical exam, OB/GYN, prostate, bone density) reported by age and gender
	15. The proportion of people whose health care recommendations have been followed
	16. The proportion of people for whom health care protocols for chronic illnesses have been followed

Outcomes	Indicators
	17. The proportion of people who have had a routine dental exam annually or as recommended by the dentist
	18. The proportion of people who maintain healthy habits in such areas as smoking, weight, and exercise
	19. The number of hospitalizations are tracked (defined as an overnight stay)
People have access to health care services and supports	20. The proportion of families who report that finding a physician knowledgeable and sensitive to their relatives with developmental disabilities is a barrier to health care
	21. The proportion of families who report that lack of accepting Medicaid payment is a barrier to health care
	22. The proportion of families who report that they are able to locate physicians in their area
	23. The proportion of families who report that a lack of assistance in finding physicians who accept Medicaid is a barrier to health care (DDDS
	24. The proportion of families that report having access to psychiatric services for their relative when needed
	25. The proportion of families that report having access to needed medications for their relative that are covered by Medicaid is a barrier to health care
People have access to mental health services	26. Psychiatric hospitalizations are tracked
The use of psychotropic medications is monitored	27. The proportion of people taking psychotropic medications
	28. The use of prescribed as needed (PRNs) medications to address behavior decreases
People are supported to have good nutrition	29. The proportion of staff who report receiving training on appropriate, nutritious menu substitutions
	30. The proportion of people whose special diets are followed
People are assisted with their personal care	31. The proportion of families who report their family member receives assistance with personal care and hygiene
	32. The proportion of providers cited for not attending to people' s personal care needs
Area of Concern: Community Inclusion	
People participate in community life	33. The proportion of people who participate in everyday integrated activities in their communities (e.g., go out to eat, use the library, exercise and/or play a sport)
	34. The proportion of people and families reporting they have adequate support to participate in community activities
	35. The proportion of people who report being involved in their communities (e.g., belong to civic/community/social organizations)

Outcomes	Indicators
Area of Concern: Relationships	
People are connected with their family	36. The proportion of family members that report they feel welcome in their relative's home
	37. The proportion of people who report they are provided with opportunities to visit with their family
People have friends and relationships	38. The proportion of people who report they are provided with opportunities to visit their friends
	39. The proportion of people who report they have opportunities to build friendships
	40. The proportion of people who report they have friends and caring relationships with people other than support staff and family members
	41. The proportion of people who report they have opportunities for significant personal relationships
	42. Proportion of people who report they have support to visit with friends
	43. Proportion of people who report they have support to see their family
Area of Concern: Community-based Employment	
People have jobs that meet their preferences and support needs	44. The proportion of people in community-based employment reported by type of employment (e.g., enclaves)
	45. Proportion of people who move from sheltered workshops to community-based employment
	46. The proportion of people who report having opportunities for job advancement
	47. The proportion of people who report transportation is not a barrier to employment
	48. People who express they want to work, are able to work (reported by living environment)
	49. Of people who have a job in the community, the average length of time people have been working at their current job
	50. The proportion of people who report the ability to change work arrangements if they desire
	51. The proportion of people who report being provided with employment choices
	52. The proportion of people who receive individualized employment supports from their job coaches
	53. The proportion of people who are satisfied with their job
	54. The proportion of people who receive individualized supports to do their job
	55. The proportion of people who are able to volunteer if they want to
People feel welcomed in their workplace	56. The proportion of people who report feeling welcomed in their workplace
People receive	57. The average monthly earnings for people who have jobs in the community

Outcomes	Indicators
commensurate wages and benefits	58. The proportion of people earning at or above the state minimum wage
	59. The average number of hours per month people work at their place of employment
	60. Of the people who have a job in the community, the proportion who receive job benefits
Systems support employment	61. A flexible model exists to support both support employment and self-direction
	62. There are efforts to education the public about the benefits of employing people with developmental disabilities
	63. Proportion of people who are able to mentor other individuals with disabilities
Area of Concern: Accommodations	
People have supportive devices and equipment that they need	64. The proportion of people who report they have necessary modifications for the home/work environments
	65. The proportion of people who have the supportive equipment identified in their plan
	66. The proportion of people who report that their supportive equipment is helpful to them
People's supportive equipment and devices are safe	67. The proportion of providers cited for having supportive equipment that is not working properly
	68. The proportion of people who report that their supportive equipment is in good working order
Area of Concern: Rights and Respect	
People exercise their rights	69. People (and those who support them) have ready access to employment laws
	70. The proportion of people who report satisfaction with the amount of privacy they have
	71. The proportion of people whose basic rights are respected by others
	72. Proportion of people who report being able to use the phone if they want to
	73. The proportion of people and families who report they know the appeal process and how to file an appeal
	74. The proportion of appeals where the original decision was upheld reported by type of appeal (e.g., ELP, eligibility)
	75. The proportion of people who have participated in activities of self-advocacy groups or other groups that address rights reported by those living at home and receiving residential supports
	76. The proportion of people without guardians who have an "advocate" or someone who speaks on their behalf
	77. The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers and social activities
	78. The proportion of people and families who used the grievance reporting process and whose grievances were resolved
	79. Proportion of people who are registered to vote

Outcomes	Indicators
People are free from unnecessary restraints and other restrictive procedures	80. The proportion of providers cited for using supportive equipment in order to restrict freedom of movement
	81. The proportion of behavior support plans that contain a highly restrictive intervention decreases
	82. The proportion of reported emergency behavior intervention strategies reported by type of intervention and by living and working arrangement
	83. The proportion of reported restraints resulting in injuries
People are respected	84. The proportion of people who report that staff are nice to them and treat them with respect
	85. The proportion of people who report that their co-workers treat them well
	86. The proportion of people indicating that their case manager listens to them and treats them with respect
People's funds are protected	87. The proportion of providers cited for poor or mismanagement of people's funds
People have access to their Money	88. The proportion of people who report having access to their spending money
	89. The proportion of people who report having funds available for personal needs
	90. The proportion of people whose plan has strategies to assist them to manage their own money
Area of Concern: Choice	
People make choices about their lives	91. The proportion of people not currently working who are able to do other activities of their own choosing
	92. The proportion of people not currently working who are satisfied with their day program and/or other activities
	93. The proportion of people who make choices about where and when they go out in the community
	94. The proportion of people who make choices about where they work or how they spend their day
	95. The proportion of people who report they choose their doctor/dentist
	96. The proportion of people who make choices about their provider
	97. The proportion of people who make choices about their case managers
	98. The proportion of people who make choices about their support staff
People make choices about where and with whom they live	99. The proportion of people who report having been provided options about where to live
	100. The proportion of people who make choices about their housemates
	101. The proportion of people age 18 and over who are supported to live in a home of their own compared to the total # of persons who receive residential services
People make choices about how they spend their money	102. The proportion of people who make choices about how they spend their money
Area of Concern: Access to Services and Supports	
People have access to community based services and supports	103. The number of referrals received reported by referral source (e.g., DOE, result of APS investigation, out-of-state) and county
	104. The proportion of eligibility applications that are completed within established timeframes (90 days for non-waiver, 45 days for waiver)

Outcomes	Indicators
	105. The proportion of applications the were incomplete/inaccurate and returned for cause
	106. The proportion of individuals determined eligible as compared to individuals determined ineligible
	107. The number of days from eligibility approval to initial contact by a family support specialist
	108. Of the number of potentially eligible students, the proportion of people who applied for DDDS services and supports
	109. Proportion of applicants for the who have an original level of care (LOC) recommendation within the required time line of 30 days
	110. Proportion of individuals who have had an LOC assessment within 365 days
	111. Proportion of LOC assessments/re-assessments that were completed correctly
	112. The proportion of families who report being satisfied with the transition from DOE to DDDS services and supports
	113. The proportion of people who transitioned from DOE to DDS services reporting they had contact with a transition coordinator
	114. Of the students who are approved for DDDS services the proportion who had a transition coordinator
Area of Concern: Individual Planning and Implementation	
People's plans reflect their needs and preferences	115. The proportion of people's records that reflect they had a choice between waiver services and an institution
	116. The proportion of IFP/ELPs that reflect people's identified needs (including health and safety risks) and preferences
	117. The proportion of IFP/ELPs that are developed in accordance with DDDS policies and procedures
	118. Proportion of ELPs that are reviewed and/or revised within 365 days
	119. The proportion of families reporting that their plan reflects what is important to them
	120. The proportion of families who report they have the information needed to skillfully plan for their services and supports
	121. The proportion of providers who have a copy of the person's current ELP in the COR
	122. The proportion of individuals and families that report needed services were not available
	123. The proportion of people's IFP/ELPS that are modified when individual needs change
People's plans are implemented	124. The proportion of services identified in people's IFP/ELP that are implemented (includes type, scope, amount, duration and frequency)
People are supported to communicate	125. Percentage of people's communication programs that are being implemented
	126. The proportion of people and families who report having access to communication devices
	127. The proportion of people who have communication devices identified in their plan
Area of Concern: Staff Stability and Competency	

Outcomes	Indicators
Staff and case managers are competent and have received training to support individuals	128. Direct support staff have been trained in the ELP process
	129. The proportion of direct support staff who have completed all mandatory trainings
	130. The proportion of staff who demonstrate competencies necessary to support the individual
	131. Percentage of staff that complete university trainings (Center for Disabilities Studies)
	132. Staff have been trained and demonstrate competency in supporting people to exercise their rights
	133. The proportion of staff who are trained and demonstrate competency in supporting people's culture
	134. The proportion of people/family's that report staff are sensitive to their culture
	135. The proportion of staff who report being satisfied with the training they receive
	136. The proportion of case managers who report they feel confident in their abilities
	137. The proportion of staff who demonstrate competencies necessary to support the individual
There is a stable workforce to support individuals	138. The crude separation rate, defined as the proportion of direct contact staff separated in the past year (under 6 months, 6-12 months, over 1 year)
	139. The length of service for all direct contact staff who separated in the past year, and for all currently employed direct staff
	140. The vacancy rate, defined as the proportion of direct contact positions that were vacant as of a specified date [May be redundant of #142]
	141. The percentage of part time staff in provider agencies
	142. The average length of time people are supported by their case manager [May need re-wording]
	143. The percentage of staff that work overtime
	144. The vacancy rate, defined as the proportion of direct contact positions that were vacant as of a specified date [May be redundant of #140]
	145. The proportion of people/families who report having enough staff
	146. The proportion of family members who report there is routine communication with their case manager
	147. The proportion of families who report that service and support staff/providers are available and capable of meeting family needs
Staff are respected and adequately compensated for their work	148. Delaware's average direct support staff wages as compared to similar professional fields (for both FT and PT)
	149. The proportion of staff who feel respected
Area of Concern: Qualified Providers	
DDDS providers are qualified to support individuals	150. The percentage of providers that are in compliance with DDDS certification standards
	151. The percentage of providers that are not subject to DDDS QA reviews that are in compliance with DDDS policies and procedures
	152. The percentage of providers sanctioned (provisional licensure, probation or termination) for non-compliance with DDDS QA reviews
	153. The proportion of providers that have completed their compliance plans within the required timelines

Outcomes	Indicators
	154. The proportion of providers that have implemented quality assurance and improvement plans and are using the information to implement strategies to improve services and supports
The system supports people to live in the most integrated setting possible	155. Percentage of people residing at Stockley compared to percentage of people living in the community [INDICATOR ONLY ADDRESSES ONE PORTION OF THIS CONCERN]
Publicly-funded services are readily available to individuals who need and qualify for them	156. Decrease in the number of people who are in the highest category of need on the registry
Racial and ethnic minorities have access to services and supports	157. The proportion of people served, by race and ethnicity, relative to their proportions in the general population
Area of Concern: Systems Performance	
The system supports people to live in the most integrated setting possible	158. The proportion of Medicaid expenditures devoted to Medicaid HCBS compared to total Medicaid long-term services expenditures
The system is financially accountable	159. The proportion of ICAP assessments used to calculate rates that are completed correctly [NOTE: NEED TO MEASURE WHETHER NEW ICAPS ARE DONE WHEN NEEDS CHANGE]
	160. The proportion of claims made by providers that are correctly submitted
	161. The proportion of provider attendance reports that match what has been billed

APPENDIX B:
DDDS QM SYSTEM PRIORITY OUTCOMES, INDICATORS & INFORMATION FLOW
June 2007

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
AREA OF CONCERN: FREEDOM FROM HARM							
People are free from serious injuries and accidents	**#1** The rate of serious injury (reported by types of injury) decreases	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	TherapServices Database	Provider System	Providers, RPD, CSP, ASP Directors Risk MGMT	Quarterly Semi-Annual	Regional Program Directors (RPD) Risk MGMT
	#3 The proportion of people who have had substantiated incidents of abuse/neglect/ mistreatment by type decreases	The state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation	PM-46 Tracking.xls	Provider System	RPD, CSP, ASP Directors (reported statewide and by provider, include providers with no reports) Risk MGMT	Semi-Annual	RPD Risk MGMT
	#4 The proportion of	There is	• DDDS NGH	System (reported	Risk MGMT	Annual	Risk

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
	provider safety items in compliance reported by category of major safety issue	continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	Regulations Results.xls • CLA (DB to be developed) DP Survey Results.xls • Shared Living Contract Review (DB to be developed)	by service type)			MGMT
	#5 The mortality rate of people served by DDDS compared to the general population of Delaware, by age and by cause of death (natural or medico-legal)	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	• Health Information Management (HIM) • Mortality Data.xls	System	Mortality Review Committee	Annual	Mortality Review Committee
People live and work in safe environments	**#7** The proportion of people who report they feel safe in their home and neighborhood	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	NCI Consumer Survey	System (reported by residential, family support/natural home and Stockley)	Risk MGMT Quality Council	Annual Annual	Community Services and Adult Special Populations (CS, ASP) Directors
	#8 The proportion of	There is	NCI Consumer Survey	System	Risk MGMT	Annual	RPD

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
	people who report they feel safe where they work or at their day program	continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate			Quality Council	Annual	CS, ASP Directors
	#11 The number of provider citations for inadequate procedures for emergencies and disasters (e.g., fire drills, evacuation plans) decreases	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	• DDDS NGH Regulations Results.xls • CLA (DB to be developed) • database.xls • DP Survey Results.xls • Shared Living Contract Review (DB to be developed)	Provider System	Provider, RPD, CSP, ASP Directors Risk MGMT	Quarterly Annual	RPD Risk MGMT

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
People receive the correct medications	**#12** The proportion of reported medication errors (reported by type of error, provider and service) decreases	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	TherapServices Database	Provider System	Provider, RPD, CSP, ASP Directors, RN Supervisors Risk MGMT	Quarterly Semi-Annual	RPD Risk MGMT
	#13 The proportion of medication errors where required PM-46 (investigation) follow-up was completed	The state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation	PM-46 database	Provider System	Provider, RPD, CSP/ASP Directors Risk MGMT	Annual Annual	RPD Risk MGMT

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
AREA OF CONCERN: HEALTH AND WELLNESS							
People receive preventative health care	**#14** The proportion of people who have routine preventive health screenings (e.g., physical exam, OB/GYN, prostate, bone density) reported by age and gender	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	Monthly Medication and Health Audit.xls	Provider System (reported by residential type) System	Provider, RPD, CSP, ASP Directors Risk MGMT Quality Council	Annual Annual Annual	RPD Risk MGMT CS, ASP Directors
	#17 The proportion of people who have had a routine dental exam annually or as recommended by the dentist	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	Monthly Medication and Health Audit.xls	Provider System (reported by residential type) System	Provider, RPD, CSP, ASP Directors Risk MGMT Quality Council	Annual Annual Annual	RPD Risk MGMT CS, ASP Directors
AREA OF CONCERN: RIGHTS AND RESPECT							
People exercise their rights	**#74** The proportion of appeals where the original decision was upheld reported by type of appeal	The processes and instruments described in the approved waiver are applied to LOC	Appeals	System (reported for eligibility appeals only)	Risk MGMT	Annual	Risk MGMT

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
		determinations					
People are respected	**#84** The proportion of people who report that staff are nice to them and treat them with respect	The state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation	NCI Consumer Survey ELP SD&S Scores.xls	System System	Quality Council Provider, RPD, CS, ASP Directors	Annual Annual	CS, ASP Directors ELP Oversight Committee
People are free from unnecessary restraints and other restrictive procedures	#82 The proportion of reported restrictive behavior intervention strategies (reported by service type, type of intervention and planned vs. emergency)	There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	TherapServices Database	System	CS and ASP Directors	Semi-Annual	CS, ASP Directors
People have access to their money	**#88** The proportion of people who report having access to their spending money		NCI Consumer Survey	System	CS, ASP Directors Quality Council	Annual Annual	CS, ASP Directors CS, ASP Directors

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
AREA OF CONCERN: CHOICE							
People make choices about where and with whom they live	**#96** The proportion of people who make choices about their provider	Participants are afforded choice between/among waiver services and providers	NCI Consumer Survey (reported by residential, family support, Stockley	System	Authorized Provider Committee, CS, ASP Directors Quality Council	Semi-Annual Annual	Authorized Provider Committee CS, ASP Directors
People make choices about where and with whom they live	**#99** The proportion of people who report having been provided options about where to live	Participants are afforded choice between/among waiver services and providers	NCI Consumer Survey	System	Authorized Provider Committee, CS, ASP Directors Quality Council	Semi-Annual Annual	Authorized Provider Committee CS, ASP Directors
	#100 The proportion of people who make choices about their housemates		NCI Consumer Survey	System	Authorized Provider Committee, CS, ASP Directors Quality Council	Semi-Annual Annual	Authorized Provider Committee CS, ASP Directors

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
AREA OF CONCERN: ACCESS TO SERVICES AND SUPPORTS							
People have access to community based services and supports	**#105** The proportion of applications that were incomplete/inaccurate and returned for cause	The state monitors LOC decisions and takes action to address inappropriate LOC determinations	OBCBS tracking database	System (reported by region)	RPD, CS, ASP Directors	Annual	CS, ASP Directors
	#109 Proportion of applicants for the who have an original level of care (LOC) recommendation within the required time line of 30 days	Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided with an individual level of care (LOC) evaluation	OBCBS Tracking system	System	Risk MGMT	Semi-Annual (regional and statewide) Annual (statewide only)	Risk MGMT
	#110 Proportion of individuals who have had an LOC re-recertification evaluation within 365 days	The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver	OBCBS Tracking system	System	CS, ASP Directors	Semi-Annual (regional and statewide) Annual (statewide only)	CS, /ASP Directors

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
	#111 Proportion of LOC assessments/re-assessments that were completed correctly	The processes and instruments described in the approved waiver are applied to LOC determinations	DMMA review all LOC certifications (returned for cause)	System	Risk MGMT	Annual	Risk MGMT
AREA OF CONCERN: INDIVIDUAL PLANNING AND IMPLEMENTATION							
People's plans reflect their needs and preferences	**#115** The proportion of people's records that reflect they had a choice between waiver services and an institution	Participants are afforded choice between waiver services and institutional care	COR-ELP HCB Waiver Material completion.xls	System	Authorized Provider Committee	Annual	Authorized Provider Committee
	#116 The proportion of IFP/ELPs that reflect people's identified needs (including health and safety risks) and preferences	Service plans address all participants assessed needs (including health and safety risk factors) , either by the provision of waiver services or through other means	COR-ELP HCB Waiver Material completion.xls ELP SD&S Scores.xls	System	ELP Oversight Committee Quality Council	Annual Annual	CS, ASP Directors CS, ASP Directors

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
	#117 The proportion of ELPs that are developed in accordance with DDDS policies and procedures	The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development	ELP SD&S Scores.xls	System	Provider, RPD, CSP, ASP Directors (report by region and provider) ELP Oversight Committee Quality Council	Annual Annual Annual	RPD ELP Oversight Committee CS, ASP Directors CS, ASP Directors
	#118 Proportion of ELPs that are reviewed and/or revised within 365 days	Service plans are updated/revised at least annually or when warranted by changes in waiver participants needs	ELP–HCB Waiver Material completion.xls	Provider System	Provider, RPD, CSP, ASP Directors ELP Oversight Committee	Quarterly Semi-Annual	RPD CS, ASP Directors
	#123 The proportion of people's IFP/ELPS that are modified when individual needs change	Service plans are updated/revised at least annually or when warranted by changes in waiver participants needs	ELP SD&S Scores.xls COR/ELP Reviews (for Shared Living)	Provider System	Provider, RPD, CSP, ASP Directors ELP Oversight Committee	Annual Annual	RPD ELP Oversight Committee

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
People's plans are implemented	**#124** The proportion of services identified in people's IFP/ELP that are implemented (includes type, scope, amount, duration and frequency)	Services are delivered in accordance with the service plan, including the type, scope, amount duration and frequency specified in the service plan	• DDDS NGH Regulations Results.xls • CLA (DB to be developed) database.xls • COR/ELP Review (for Shared Living)	Provider (NGH, CLA, Day Service, Shared Living) System	Provider, RPD, CSP, ASP Directors ELP Oversight Committee Quality Council	Annual Annual Annual	RPD CS, ASP Directors
AREA OF CONCERN: STAFF STABILITY AND COMPETENCY							
Staff and case managers are competent and have received training to support individuals	**#129** The proportion of direct support staff who have completed all mandatory trainings	The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver	Train Track Access database	Provider System	Provider, RPD, CSP, ASP Directors Risk MGMT Quality Council	Quarterly Semi-annual Annual	RPD Risk MGMT CS, ASP Directors
	#130 The proportion of staff who demonstrate competencies necessary to support the individual	The state implements its policies and procedures for verifying that training is	Train Track Access database Certified Developmental Specialist certification Tracking (in development)	Provider System	Provider, RPD, CSP, ASP Directors Risk MGMT	Quarterly Semi-	RPD Risk

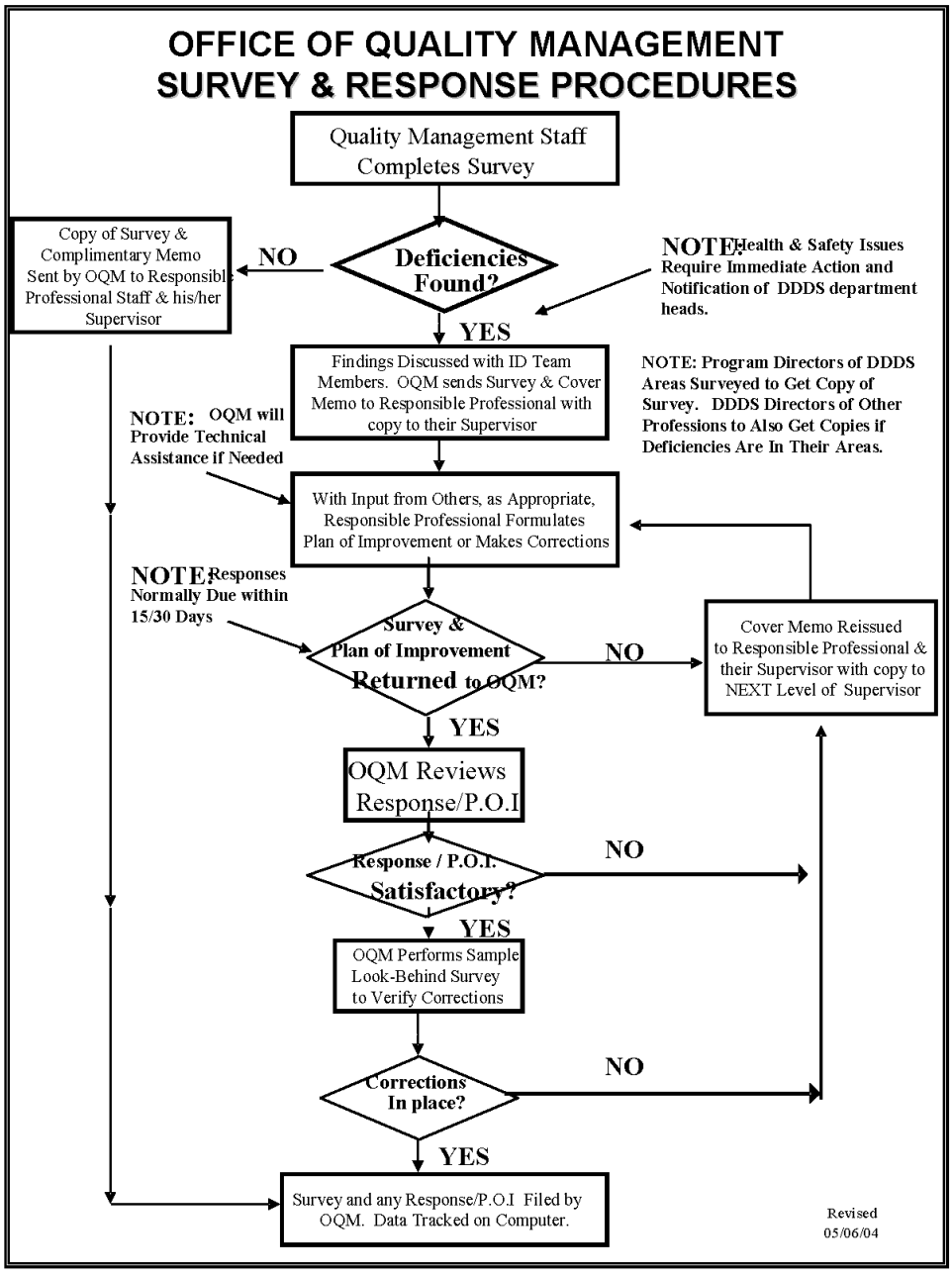
Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
		provided in accordance with state requirements and the approved waiver			Quality Council	annual Annual	MGMT CS, ASP Directors
AREA OF CONCERN: QUALIFIED PROVIDERS							
DDDS providers are qualified to support individuals	**#150** The percentage of providers that are in compliance with DDDS certification standards	The state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards	DDDS NGH Regulations Results.xls CLA (DB to be developed) DP Survey Results.xls	Provider System	Provider, RPD, CSP, ASP Directors Authorized Provider Committee	Semi-annual Annual	RPD Authorized Provider Committee
	#151 The percentage of providers that are not subject to licensing/certification that are in compliance with DDDS policies and procedures	The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements	Shared Living (single placements	Provider System	Provider, RPD, CSP, ASP Directors Authorized Provider Committee	Semi-annual Annual	RPD Authorized Provider Committee
	#152 The percentage of providers sanctioned	The state verifies on a periodic basis	Notification letters to providers	System	Authorized provider Committee	Annual	Authorized provider Committee

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
	(provisional license; probation, termination) for non-compliance with DDDS QA reviews	that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards	No formal database regarding Providers sanctioned				
	#153 The proportion of providers that have completed their compliance plans within the required timelines	The state verifies, on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards	DDDS NGH Regulations Results.xls CLA (DB to be developed) DP Survey Results.xls	Provider System	Provider, RPD, CSP, ASP Directors (also a report on repeat deficiencies) Authorized Provider Committee	Semi-annual Annual	RPD Authorized Provider Committee
AREA OF CONCERN: SYSTEMS PERFORMANCE							
The system is financially accountable	**#159** The proportion of ICAP assessments used to calculate rates that are completed correctly	Claims for Federal financial participation in the costs of waiver services are based on state payments					

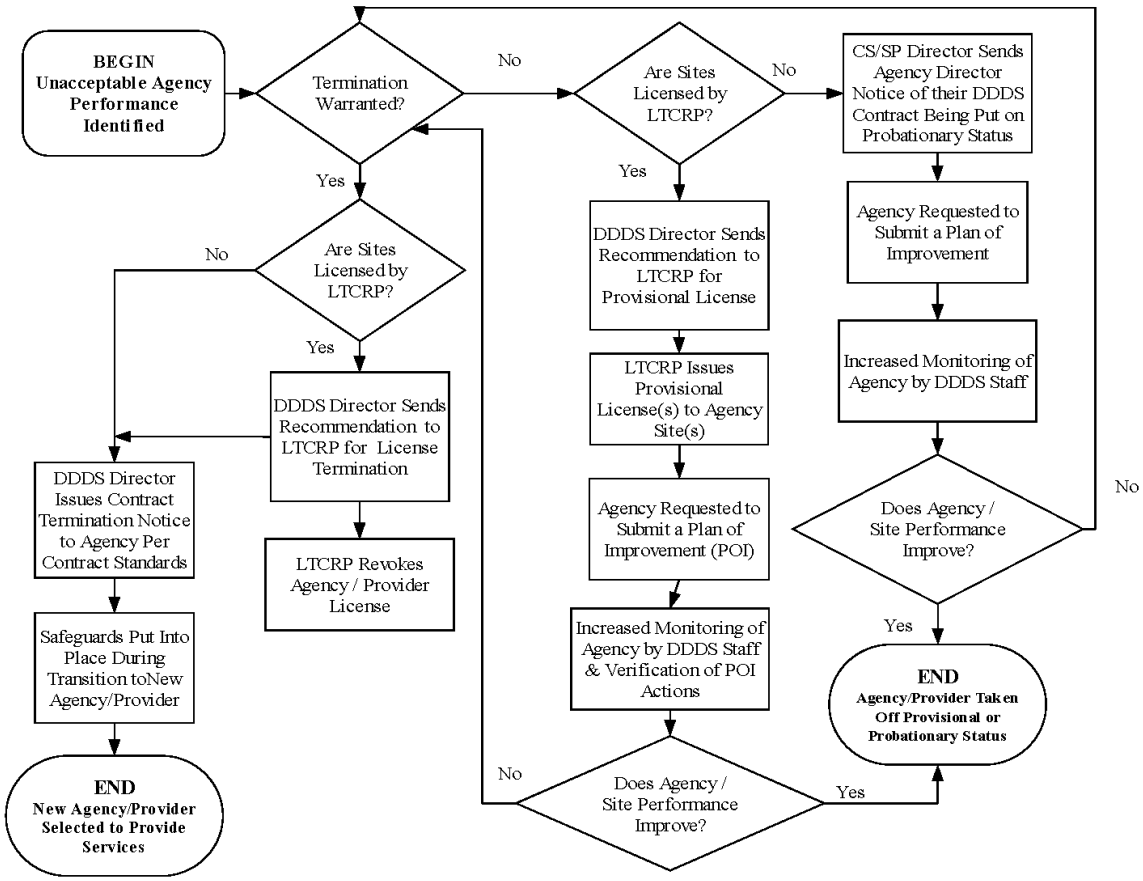
Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
		for waiver services that have been rendered to waiver participants, authorized in the service plan and properly billed by qualified providers in accordance with the approved waiver					
	#160 The proportion of claims made by providers that are correctly submitted	Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan and properly billed by qualified providers in					

Outcomes	Indicators	CMS Assurances	Data Source(s)	Continuous Quality Improvement Information Flow			
				Trends Reports (Provider/System Levels)	Who Receives Information	Report Frequency	Who Verifies Actions Taken
		accordance with the approved waiver					
	#161 The proportion of provider attendance reports that match what has been billed	Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan and properly billed by qualified providers in accordance with the approved waiver	• EDS REPORTS				

APPENDIX C:
OFFICE OF QM SURVEY AND RESPONSE PROCEDURES FLOWCHART



APPENDIX D:
PROCEDURE FOR ADDRESSING INADEQUATE HCB PROVIDER PERFORMANCE



APPENDIX E:
DDDS PERFORMANCE MEASURE SPECIFICATION WORKSHEET

Date:

Domain	
Outcome	
Indicator	

Performance Measure	

Data Source(s): (e.g., type of data source; frequency; sampling methods)	
Responsible Group/Person:	
Numerator:	
Denominator:	
Data Definitions (when needed)	
Data Collection Time Period	
Inclusions/Exclusions: Age/Gender Group: (Sub-categories)	
Population/Services/Payer: (Sub-categories)	
Risk Adjustment:	
Management Reports:	
Additional Comments:	

APPENDIX F:
DDDS PERFORMANCE ANALYSIS COMMITTEE POLICY AND PROCEDURE

Delaware Health and Social Services
Division of Developmental Disabilities Services
Dover, Delaware

Title: Performance Analysis Committee **Approved By: _____**
Division Director

Written/Revised By: DDDS Policy and Records Committee **Date of Origin: April 13, 2007**

Date of Current Review/Revision: _____

I. PURPOSE

To establish a Performance Analysis Committee that is charged with the collection, analysis and reporting of data used to measure the Division's performance on quality-related objectives it has set for itself.

II. POLICY

The Division shall collect, analyze and trend data regarding performance indicators identified as important by consumers, stakeholders and administrative authorities with the aim of effecting improvements in its service delivery system.

III. APPLICATION

DDDS Employees and Contractors

IV. DEFINITIONS

A. Performance Analysis Committee (PAC) - An administrative committee appointed by the Division Director to collect, review and analyze data for the purpose of measuring the Division's adherence to performance measures/priority indicators. The PAC presents analytical reports to various DDDS quality-related committees (e.g., Risk Management, Authorized Provider Committee, Quality Council, etc) and administrators on a pre-determined frequency or as requested.

B. Performance Analysis Committee Chairperson - The person appointed by the Division Director who is responsible for directing the work of the Performance Analysis Committee (PAC). Responsibilities shall minimally include the establishment of meeting agendas and communicating quality management strategies and techniques with the Office of Quality Management, various DDDS committees (e.g., Division's System Change Grant Committee, the Risk Management Committee), the DDDS Executive Staff and applicable contractors.

C. Quality Management Strategy - A crucial operational feature used by an organization to determine whether it operates in accordance with approved program designs, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies improvement opportunities.

D. Data Analysis Report - A quality management report designed to present the outcome of a specific performance indicator(s). Such reports are designed to maximize understanding and readability by a broad audience and include the following elements: the indicator that is being measured; source(s) of data; displays of the data; analysis of the data in relation to the performance indicator; and a description of past improvement strategies and their resultant effectiveness, when known.

E. Systems Improvement Strategy Report (SISR) Form – A form to be used by quality-related committees referenced in this policy, other committees, DDDS administrators, as well as contracted service providers to document and report to the PAC Chairperson any systems-level quality improvement initiatives they have taken. These forms and the information contained will be used to track improvement efforts across the division and be used to compile periodic quality reports to the Centers for Medicare and Medicaid Services (CMS).

V. STANDARDS

A. The Performance Analysis Committee shall oversee the Division's quality management strategies/data sources to ensure that the information collected provides the most accurate measure of performance of the DDDS service delivery system.

B. The Performance Analysis Committee shall aggregate and analyze data on each of the priority Performance Indicators and report on such to the DDDS Executive Staff, Senior Management Staff and various quality-related DDDS committees. Such reports will be in the form of a Data Analysis Report (see Exhibit C) and will strive to remain as objective as possible, refraining from making judgments or system improvement recommendations. Such will be the responsibility of the quality related committees and division authorities who receive these Data Analysis Reports.

C. The Performance Analysis Committee shall assist the Division Director/Executive Staff in the development, maintenance and update of a centralized set of desired outcomes and accompanying performance indicators which have been identified by people served, families, administration and other stakeholders as desirable in the DDDS service delivery system.

D. The Performance Analysis Committee shall interface with Information Technology (IT) with regards to the following activities:
   1. Identifying strengths and weaknesses of data sources that are related to performance indicators;
   2. Recommending data base changes and improvements;

3. Developing specifications and standardizations for outcome/indicator data collection to be used in the design of any data collection software program;
4. Making recommendations on ways of storing collected data so such is easily retrievable and available for analysis.

E. The Performance Analysis Committee shall monitor the Division's efforts at QA/QI and its use of discovery, remediation and improvement processes to determine trends and the effectiveness of Quality Management work plans and performance improvement strategies.

F. The Performance Analysis Committee shall be responsible for keeping an on-going compilation of the various systems improvement efforts (see Exhibit D) made by the Division and communicating such to federal funding entities (i.e. CMS) in annual 373Q and other HCB Waiver-related evidentiary reports, or as otherwise requested.

VI. PROCEDURES

People served and their families, DDDS staff and administration, Providers, etc.	1. Identify Performance Measures indicative of a quality MR/DD service delivery system. Revise and update over time.
DDDS Director & Executive Staff	2. Prioritize indicators into a manageable number able to be measured and reported on – being sure that each CMS assurance is addressed.
Performance Analysis Committee	3. Identify data sources and specific objectives used to measure the Division's success in meeting each Performance Indicator. Complete a Performance Measure Specifications Worksheet on each prioritized performance indicator. Identify frequency of reports and the quality-related committees/DDDS administrative entities to receive them. 4. Using existing data sources, compile Data Analysis Reports for quality-related committees/DDDS administrators. PAC member(s) present reports to committees.
Quality-Related Committee(s) / DDDS Administrators	5. Discuss information in the Data Analysis Reports, as presented by PAC member. Identifies system-wide area(s), if any, that need improvement. Takes appropriate action to effect those improvements. Further information may be sought from PAC or other entities. In developing an improvement strategy, the task may be delegated to individuals or ad hoc groups having more expertise, or may be done by the quality-related committee itself.

Quality-Related Committee / DDDS Administrators / Agency Directors / Others	6.	Completes a Systems Improvement Strategy Report (SISR) Form (Exhibit D) as to what changes will be made to make service delivery or other improvements. Secures any necessary administrative approval, including that of the DDDS Director, and forwards completed form to the PAC Chairperson.
PAC Chairperson	7.	Reviews SISR Form as to match with an existing DDDS Performance Indicators, as well as the author's methodology of collecting information/data to measure strategy success. Assists when and where needed. Files SISR Form according the Performance Indicator it addresses.
PAC Chairperson / PAC Committee Members	8.	Tracks success of improvement efforts and reports on such in subsequent Data Analysis Reports to responsible quality-related committee/DDDS Administrator(s)
Quality-Related Committee(s) / DDDS Administrators	9.	Reviews the Data Analysis Report and, as necessary, revises improvement strategies to closer meet Performance Indicator objective.
DDDS Director / Quality-Related Committee(s) / DDDS Administrators	10.	Over time identifies new priority Performance Indicators to be actively worked on or, as warranted by evidence, moves Performance Indicators on which objectives have been accomplished, to a less priority status.
PAC Chairperson	11.	Compiles annual reports for CMS, Quality Council, etc. as to the overall efforts of DDDS in meeting priority Performance Indicator objectives and the various efforts made by DDDS to improve services.

VII. SYNOPSIS

This policy outlines the responsibilities of the DDDS Performance Analysis Committee. As the committee develops, so will its role and responsibilities.

VIII. REFERENCES

A Home and Community Based Services: Quality Management Roles and Responsibilities, Maureen Booth et al of the Rutgers Center for State Health Policy.

IX. EXHIBITS

A. Performance Analysis Committee Membership
B. Continuous Quality Improvement Cycle Flow Chart

C. Format for Data Analysis Report
D. Systems Improvement Strategy Report Form

EXHIBIT A

PERFORMANCE ANALYSIS COMMITTEE MEMBERSHIP

Members	Department
Scott Phillips	Office of Quality Management / Chairperson
Evalyn Briddell	Office of Quality Management
Jeanne Lawson	Community Services Day Services
Pat Weygandt	Director's Office, Residential Development
Debra Miller	NCC Office of Quality Management
Vacant	K/S Office of Quality Management
Vanessa Deloach	Community Services Director's Office
Lew Miller	Director's Office
Pauline Barcus	Stockley Center
Vacant	Ad Hoc Member

EXHIBIT B

Continuous Quality Improvement Cycle Flow Chart

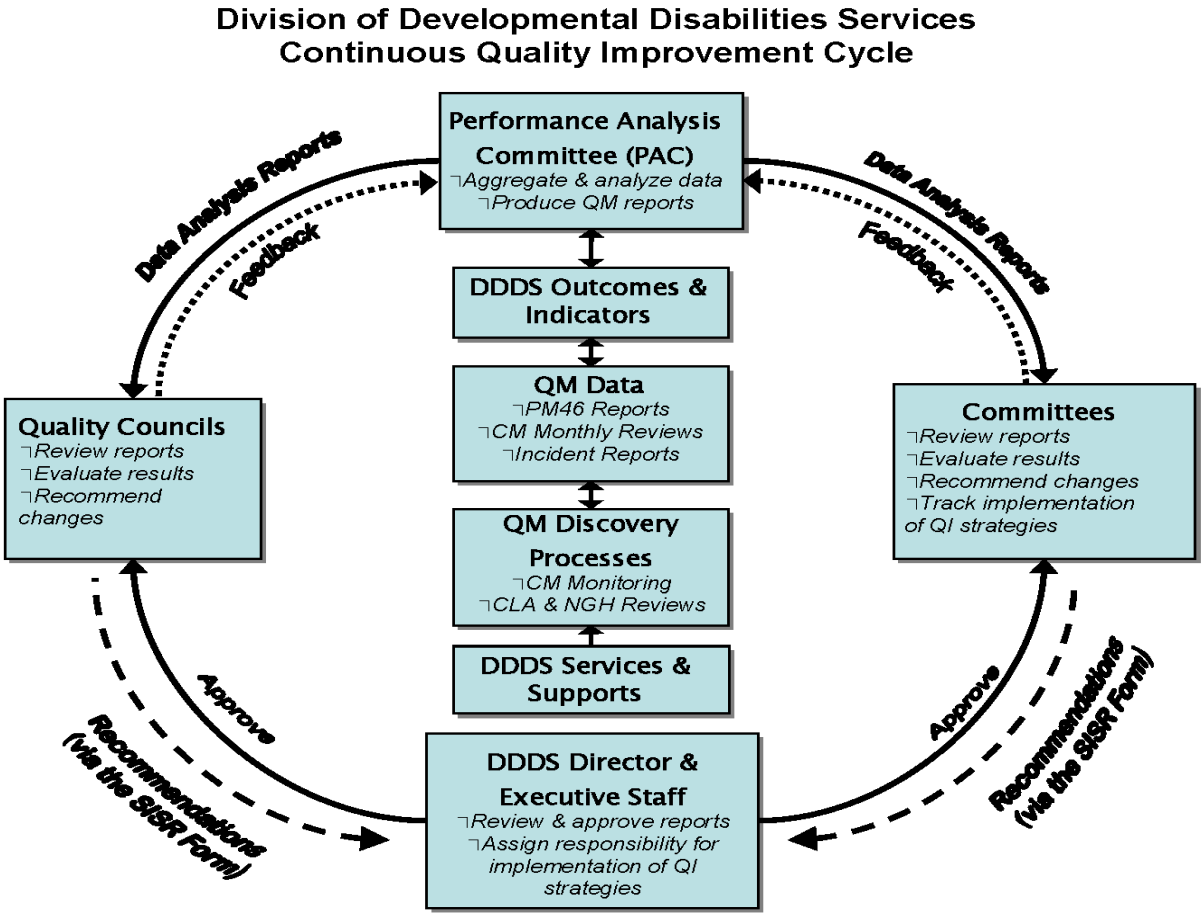


EXHIBIT C

Division of Developmental Disabilities Services
Home and Community-Based Waiver Services
DATA ANALYSIS REPORT

Reporting period: *Time period of data review* **Date:** *Date of report*

Prepared by: *PAC member(s) preparing report*

Prepared for: *The primary quality-related review committee/person(s) responsible for reviewing report, formulating improvement strategies*

CMS Assurance:

The specific system-related assurance mandated by CMS that states address in their quality management strategies

State Domain / Outcome / Performance Indicator:

Pinpoints the specific performance indicator(s) addressed in the report and the corresponding global domain and desired outcome under which the indicator falls.

Abstract:

Brief synopsis of the report presenting most significant findings

Data Source:

What is the source of the information; who collects/maintains it; frequency of data collection/information gathering etc.; who follows-up and who has authority to ensure that necessary actions are taken?

Should also describe what portion of the population is covered (e.g., adults, waiver recipients), what services are covered (e.g., employment/day, residential),

what dates the data represents (e.g., last three months, year, fiscal year) and if this represents the whole population of a sample.

Data:

Presentation of the aggregate data displaying statewide and sub-state trends (where applicable). The presentation should be in easy to follow formats such as pie charts, bar graphs etc. Note that it is helpful to the state and CMS if the current data is compared to data from previous reports. Where needed, provide a brief explanation of what the data means. For example, if aggregate data shows the % of provider compliance issues, present the data in terms of the total number of providers surveyed. Displays of raw, un-aggregated data should be avoided (e.g., list of critical incidents, listing of results of all provider surveys).

Analysis:

State's written analysis of the data noting significant trends that will warrant follow-up and improvement strategies. This should compliment the previous section and be used as a means of highlighting specific issues that be presented in the next section. Note that this can be combined with the previous section.

Conclusions and actions taken/improvement strategies for the reporting period:

Discussion of the state's improvement plan including strategies, how it will be implemented, and who will be responsible for monitoring implementation.

Follow-up on actions taken from previous reporting periods:

Provides an update on the progress of an improvement strategy has already been implemented.

PARC Reviewed and Approved: 03/27/07
Form #: Admin 47

EXHIBIT D

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
SYSTEMS IMPROVEMENT STRATEGY REPORT FORM

Date:
No.:

Performance Indicator

(if known / applicable)

Prepared By:

Position:

Improvement Strategy to be Implemented:

Brief Description of Problem Addressed:

Desired Outcome:

How will Outcome be Measured:

Expected Date Strategy will be Implemented:

Parties Responsible for Implementing Improvement Strategies:

Send Completed Form to PAC Chairperson, Office Quality Management, 26351 Patriots Way, Georgetown, DE

PARC Reviewed and Approved: 03/27/07
Form #: Admin 47

APPENDIX G:

Draft Outline for the DDDS Quality Council

Purpose

The Quality Council shall be a statewide advisory council which will identify issues and make recommendations to the Director of the Division of Developmental Disabilities Services for improving division-wide services and systems.

Members/Tenure

1. A letter from the Division Director will be sent to the advocacy community, the Center for Disabilities Studies, provider agencies, foster care providers, individuals, and families announcing that the Division is seeking interested applicants to serve on a Quality Council. The announcement shall also be posted on the DDDS website. Copies of the application shall be enclosed with the letter, and the application shall also be posted on the DDDS website. (Draft application attached).

2. Completed applications should be sent to the Director of Policy Development who will present the applications to the Division Director's Executive Staff and the Quality Council liaison for review and recommendation. Final appointments shall be at the discretion of the Division Director.

3. Members will be appointed for a three year time period. Members can re-apply to be appointed for another three years, however members may only re-apply once.

4. The Quality Council shall have no more than 18 total members.

5. 51% (10) of the members shall be families/individuals.

6. Other members shall include a representative from Stockley Center, Community Services/Adult Special Populations, a representative from the DDDS Performance Analysis Committee (PAC), foster care providers, and provider agencies.

7. The Division Director shall appoint a DDDS staff member to serve as a liaison to the Quality Council.

8. A chairperson shall be appointed from within the Quality Council.

Operations

1. The Quality Council members shall develop the council's Code of Conduct, charter, and bylaws. Items for consideration shall include but not be limited to:
    a. Attendance policy
    b. Be customer focused

c. Be supportive of an outcome-oriented process
d. Get along with others
e. Be open to ideas
f. Communicate effectively and with respect
g. Active participation

2. All members will be required to sign and agree to abide by the Code of Conduct.

3. The chairperson may make recommendation for a member's dismissal to the Division Director.

4. All members serve at the pleasure of the Division Director.

5. Roles & Responsibilities
    a. Will review aggregate data from areas such as the Mortality Review Committee, unusual incident reports, abuse allegations, Neighborhood Home Certifications, Consumer Satisfaction Surveys, National Core Indicator Project, and foster care. Additional data may be added over time.
    b. Data reviewed will not contain any individual or provider specific information.
    c. The Quality Council shall serve in an advisory capacity to the Division Director. As such, any recommendations made by the council are subject to final review and approval by the Division Director.
    d. The Division Director shall provide communication back to the council regarding any recommendations made.
    e. Committees or subgroups may be formed in order to work on specific topics/activities.
    f. The council can request to have guests attend meetings to present information about specific topics or DDDS committees.
    g. Council members will receive an agenda and any relevant materials 2 weeks prior to meetings. Council members have a responsibility to review the materials and come to meetings prepared.

6. Decision making and the resolution of disagreements shall be made by majority vote with the recording of dissenting votes. The chairperson shall only vote in the event of a tie.

Logistics

1. The first meeting shall be for orientation and training. The council shall meet the next two consecutive months. At that time, the council shall decide how frequently meetings shall be held. At a minimum, meetings shall be held quarterly.
2. The meetings shall be held in Dover since it is centrally located. The location shall be accessible.

3. The day and time of the meetings shall be determined by the council.

4. The chairperson and the liaison shall develop the agenda collaboratively. Each meeting shall allow time for public comment.

5. The agenda shall be sent to each council member and be publicly posted 2 weeks prior to the meetings. Each agenda shall include a contact number for people who need to request special accommodations.

6. The chairperson shall lead the meetings. The liaison shall lead the meetings in the chairperson's absence.

7. DDDS shall provide clerical support for recording and distributing minutes. Clerical support shall be assigned by the Division Director.

8. Meeting minutes shall be provided to each council member and also be publicly posted.

9. The presence of no less than 5 family/individual council members plus 5 other council members, including the chair, shall constitute a quorum for the official conduct of business.

10. Requests for reimbursement to offset transportation and attendant care costs shall be submitted to the Chief of Administration. Approval will be determined by available resources. A line item for council reimbursement shall be established within the DDDS budget.
(A request for reimbursement form will need to be developed – Valerie???)

Training / On-going Support

1. HSRI will provide the initial training. *(Perhaps HSRI could provide train the trainer training, and the Center for Disabilities Studies could be trained to be future trainers. The Center for Disabilities Studies will need to be contacted to see if they are interested in being involved).*
2. Council members will receive initial and on-going training.

3. The Center for Disabilities Studies shall be used as a resource for linking self-advocates with mentors who will assist self-advocates with becoming comfortable with their role and the material being reviewed.
4. The Center for Disabilities Studies shall provide any needed training to the mentors. Mentors should be willing to meet with the individual prior to the meeting, assist the individual during the meeting, and review material covered after the meeting.

Sustainability

1. The council will determine if it is functioning effectively via feedback from the Division Director and the liaison, continuous review of data, and a member survey.

Appendix M: Project Director Resume

FINDING A WAY HOME
PARTICIPANT EMERGENCY BACK-UP PLAN - DRAFT

Participant Name:_____ Date:_____

The following procedures are in place in case of a non-medical emergency related to your care (for example, worker does not show up, equipment failure).

1. Implement the back-up procedures described in your care plan if applicable to the emergency situation.

    a. Formal Back up Plan for Services:
    - **Wheelchair repair**: Chesapeake Rehab, Mary Kate, phone: 1-800-675-6789
    - **Hoyer Lift repair**: Happy Harry's, June Mohr, phone #: 1-800-335-0732
    - **Personal Assistant Back up**: Assistant Mary, phone #: 857-1223, Agency contact: John Baker, Supervisor, phone #: 857-1235
    - **Transportation issues to/from Day Care**: Easter Seals Transportation Coordinator May Bowl, phone #: 667-9835
    - **Transportation to/from other medical appointments**: Logisticare Coordinator, Lorraine Reynolds, phone # 888-123-5567

    b. Informal Back up Plan:
    - Contact your **spouse**, work number:, cell #:
    - Contact your **neighbor** John, home phone #: , cell #:
    - Your **friend** , home phone #:, cell #:

2. During business hours, contact your Waiver case manager or Transition Coordinator:

    Case Manager Name:

    Phone #:

    Transition Coordinator Name:

    Phone #:

    If your CM is not available, you can talk to another person at the agency by following these instructions to speak to back-up staff: DSAAPD Supervisor,

3. For after-hours assistance, you should call:.

4. **In case of a medical emergency, please call 911.**

This completed form must be provided to each participant in the Finding A Way Home program by the Transition Coordinator.

Appendix O: Critical Incident Reporting Process and Form

FINDING A WAY HOME
CRITICAL INCIDENT REPORTING - DRAFT

Reportable Critical Incidents Defined:

1. **Abuse / Neglect / Exploitation**
2. **Medical Emergency**
3. **Rights Violations**
4. **Restraints**
5. **Serious Injury**
6. **Medical Errors**
7. **Missing Person**
8. **Law Enforcement Contact**
9. **Death**
10. **Suicide Attempt**

General Definition
A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a waiver participant.

Who is supposed to report a critical incident?
Any person who becomes aware of a critical incident as defined on this form.
Qualified Service Providers that are enrolled with the Department of Humans Services, Transition Coordinators and Case Managers are required to report incidents

How do you report a critical incident?
Individuals wishing to report an incident can contact any of the following persons:

• Transition Coordinator: Name _____
  Agency_____
  Address_____
  Phone Number_____

• Waiver or CCAP Case Manager Name _____
  Agency_____
  Address_____
  Phone Number_____

• ***Finding A Way Home*** Program Manager, Division of Medicaid & Medical Assistance, The Lewis Building, 1901 N. Dupont Highway, New Castle, DE 19720, 1-800-372-2022, (302) 255-9500

Reporting Process
The critical incidents report form will be completed by the Transitional Coordinator, Case Manager, or the ***Finding A Way Home*** Program Manager. Action will be taken to resolve the concerns and a follow-up plan will be developed.

Critical Incidents

1. **Abuse**
    a. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any person with developmental disabilities;
    b. Knowing, reckless, or intentional acts or failures to act which cause injury or death to a developmentally disabled or mentally ill person or which placed that person at risk of injury or death;
    c. Rape or sexual assault of a developmentally disabled or mentally ill person;
    d. Corporal punishment or striking of a developmentally disabled or mentally ill person;
    e. Unauthorized use or the use of excessive force in the placement of bodily restraints on a developmentally disabled or mentally ill person; and
    f. Use of bodily or chemical restraints on a developmentally disabled or mentally ill person which is not in compliance with federal or state laws and administrative regulations.

2. **Exploitation**
    An act committed by a caretaker or relative of, or any person in a fiduciary relationship with, a person with a disability, that involves:
    a. The taking or misuse of property or resources of a person with developmental disabilities or mental illness by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means;
    b. The use of the services of a person with developmental disabilities or mental illness without just compensation; or
    c. The use of a person with developmental disabilities or mental illness for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish to the person with developmental disabilities or mental illness.

3. **Neglect**
    a. Inability of a person with disabilities to provide food, shelter, clothing, health care, or services necessary to maintain the mental and physical health of that person;
    b. Failure by any caretaker of a person with developmental disabilities or mental illness to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care of persons with developmental disabilities or mental illnesses;
    c. Negligent act or omission by any caretaker which causes injury or death to a person with developmental disabilities or mental illness or which places that person at risk of injury or death;
    d. Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan for a person with developmental disabilities or mental illness;
    e. Failure by any caretaker to provide adequate nutrition, clothing, or health care to a person with developmental disabilities or mental illness;
    f. Failure by any caretaker to provide a safe environment for a person with developmental disabilities or mental illness; and
    g. Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services for persons with developmental disabilities or mental illnesses.

4. **Rights Violations:** Through omission or commission, the failure to comply with the rights to which an individual with a disability is entitled as established by law, rule, regulation, or policy.

5. **Serious Injury**: Reported, regardless of the cause or setting in which it occurred, when an individual sustains:
   - o A fracture
   - o A dislocation of any joint
   - o An internal injury
   - o A contusion larger than 2.5 inches in diameter
   - o Any other injury determined to be serious by a physician, physician assistant, registered nurse, licensed vocational nurse/licensed practical nurse.

6. **Missing Person:** Whenever there is police contact regarding a missing person regardless of the amount of time the person was missing
   - □ During a period of time in which a program provider is responsible for supervision of program participant/consumer.
   - □ Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

7. **Death:** The death of an individual is reported, regardless of the cause or setting in which it occurred.
   - □ During a period of time in which a program provider is responsible for supervision of program participant/consumer.
   - □ Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

8. **Medical & Psychiatric Emergency**: Admission of an individual to a hospital or psychiatric facility or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a primary care provider.

Use Of:
- □ Emergency Medical Services (example*: emergency room care)
- □ Emergency Psychiatric Services (example*: mental health facility admission)
- □ Life Saving Intervention (example*: Heimlich, CPR) – * Example is just one of several possible scenarios

9. **Restraints**: Every time an individual is restrained
   - □ Personal (the application of pressure, except physical guidance or prompting of brief duration, that restricts the free movement of part or all of an individual's body)
   - □ Mechanical (the use of a device that restricts the free movement of part or all of an individual's body. Such devise includes an anklet, a wristlet, a camisole, a helmet with fasteners, a muff with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure.) It also means to

cause a device that allows for free movement to be useable. Such as locking a wheelchair or not allowing an individual access to technology.

- Chemical (the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition).
- Included In A Written And Approved Behavior Plan
- Not Included In a Written and Approved Behavior Plan
- Seclusion: involuntary confinement in a room that the person is physically prevented from leaving.
- Isolation: forced separation or failure to include the person in the social surroundings of the setting or community.

10. **Medication Discrepancy:** When there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication discrepancy is when one or more of the following occurs:
    a. Wrong medication: an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was improperly labeled.
    b. Wrong dose: An individual takes a dose of medication other than the dose that was prescribed.
    c. Omitted dose: An individual does not take a prescribed dose of medication within the 24-hour period of a calendar day. An omitted dose does not include an individual's refusal to take medication.
    d. Dose Refused: An individual's refusal to take medication resulting in a medical emergency or use of restraint.

11. **Law Enforcement Contact:** A person receiving services is charged with a crime or is the subject of a police investigation, which may lead to criminal charges; an individual is a victim of a crime against the person; crisis intervention involving police or law enforcement personnel.

12. **Suicide Attempt:** The intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a person receiving services.

Review

Critical incident reports will be completed by the Transition Coordinator or the HCBS Case Manger and forwarded to the ***Finding A Way Home*** Project Director for processing.

The Project Director will respond to each incident based on need and significance. Copies of all incident reports will be maintained in the ***Finding A Way Home*** participants file and reviewed as part of the program's quality assurance process.

Critical Incident Report Form

Consumer Name: _____

Address:_____City_____County_____

Phone No:_____ Date of Birth: _____Medicaid #:_____

Incident Details	Additional Information
Person Reporting Incident: _____ Address: _____ Phone Number: _____	
Title or Relationship of Person Reporting Incident:	
Date and Time Incident Report Completed:	
Location where incident took place: Date: _____Time:_____	
Type of Event: Check All That Apply ☐ Abuse/Neglect/Exploitation ☐ Rights Violations ☐ Serious Injury ☐ Missing Persons ☐ Death ☐ Medical Emergency ☐ Restraints/Seclusion/Isolation ☐ Medical Error ☐ Law Enforcement Contact ☐ Suicide Attempt	
Description of Event:	If the event involves the use of Restraint / Seclusion /Isolation provide the following details: Type, Date, Time, Length: _____
Name(s) and role(s) of All Involved in Incident:	

Names of Those Who Witnessed Incident:	
Immediate Action or Response to the Incident by the Reporter:	
Name of Case Manager or Transitional Coordinator Filing and Reporting the Incident Form: Agency: _____ Phone Number: _____ E-Mail Address: _____	
Medical Treatment Provided to Person Involved in Incident:	Treatment Provider Data: Name: _____ Address: _____ Phone Number:_____
Contacts Made on Behalf of Consumer: (Ombudsman, Protection and Advocacy, Law Enforcement, Child Protective Services, Adult Protective Services, etc.)	The Date and Name of the Consumer's HCBS Case Manager or Transition Coordinator Notified of Incident:
Names and Relationships of Those Contacted on Behalf of the Person Involved in the Incident (Legal Representative, Relatives, Friends, or other informal supports):	
Action Taken to resolve concerns by Case Manager or Transitional Coordinator:	

FINDING A WAY HOME **Project Director Actions**	
Date and Time Incident Report Received or Filed with Medical Services: _____	
Concern(s) Identified:	
Action Taken to Resolve Concerns:	Date of Action Taken:
Follow-up Planned:	

Appendix P: Participant's Rights & Responsibilities

FINDING A WAY HOME
PARTICIPANTS' RIGHTS AND RESPONSIBILITIES

PARTICIPANT'S RIGHTS

- **RIGHT TO NONDISCRIMINATION**
  In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, the Money Follows the Person Demonstration Program is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation.

  To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call, toll free, (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer**.**

- **RIGHT TO CONFIDENTIALITY**
  You have the right to have your personal information treated confidentially. We keep information you give confidential and use it only to administer the Money Follows the Person program. Any person who knowingly violates our confidentiality policy, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or undergo imprisonment, not exceeding six months, or both.

- **RIGHT TO EXPERIENCE DIGNITY OF RISK**
  You have the right to make choices that others may support or see as dangerous or not appropriate. As everyone else, you are responsible for the consequences of that risk.

- **RIGHT TO APPROPRIATE MEDICAL CARE AND PERSONAL SUPPORT**
  You have the right to appropriate medical care and support. Your decisions and choices will be respected by providers of services.

- **RIGHT TO RECEIVE INFORMATION ABOUT AND TO CHOOSE YOUR MEDICAL & SUPPORT SERVICE PROVIDERS**
  You have the right to have information about community services available to you and to choose the manner in which the services will be provided.

  You have the right to select the medical and/or service provider of your choice.

  You also have the right to change medical providers if and when you choose.

- **RIGHT TO CONTROL YOUR PERSONAL FINANCES**
  You have the right to receive any income, benefits, and other financial resources that are in your name. You have the right to spend your money as you see fit. If needed, you can receive personal support services to assist in the management of funds and other resources such as personal clothing and possessions.

- **RIGHT TO BE TREATED WITH RESPECT, DIGNITY AND HONESTY**
  You have the right to be treated in a courteous and respectful manner and to be free from mental, physical, and financial abuse.

- **RIGHT TO BE TREATED AS AN INDIVIDUAL**
  You have the right to be dealt with in a manner that recognizes your individuality and that responds to your needs and preferences. This includes preferences based on ethnic, spiritual, linguistic, familial, and cultural factors.

- **RIGHT TO CONTINUITY OF CARE**
  If you are receiving support from an agency, the only reasons for the agency to end services will be:
    i. Medically based reasons;
    ii. Nonpayment

  The agency must give you the reasons in writing 30 days before they end the service. A written explanation of your right to appeal must accompany any written service termination letter.

- **RIGHT TO LIVE INDEPENDENTLY AND SAFELY**
  You have the right to live as independently, actively and fully as desired.

  You have the right to live safely in a healthy environment.

  You also have the right remain in the facility or to return to a facility.

- **RIGHT TO PARTICIPATE IN YOUR PROGRAM ASSESSMENT AND TRANSITION PLAN**
  You have the right to participate in the assessment of your Money Follows the Person requirements, development of your transition plan, review of your requirements, evaluation and revision of your transition plan.

  You have the right to participate in planning and reviewing your community-based services.

  You have the right to make your needs and expectations known.

- **RIGHT TO TIMELY NOTIFICATION**
  You have the right to know of any changes to the ***Finding A Way Home*** Program in a timely manner. You also have the right to receive timely notification of any changes to the services you receive.

- **RIGHT TO LODGE A COMPLAINT AND/OR APPEAL**
  You have the right to raise concerns or recommend changes in connection with the community services provided to you and in connection with policies and decisions that affect your interests, to your service provider, government officials or any other person, without fear of interference, coercion, discrimination or reprisal.

  You have the right to appeal any denials or reductions in services through the Division of Medicaid & Medical Assistance hearing process.

- **RIGHT TO INFORMED CONSENT**
  You have the right to give your consent only when you understand fully to what you are agreeing.

  You have the right to ask questions or request the information in an alternative format to ensure full understanding of the process and information being presented.

  You have the right to receive information about the rights and rules regarding the Money Follows the Person program. This information must be explained to you so that you understand what each right means and how it applies to you. If you require this information in alternative format, manner or in a language other than English, please let your Transition Coordinator know.

  You have the right to give or refuse consent to the provision of any community service.

- **RIGHT TO BACK-UP SUPPORT**
  You have the right to know and review your Back-Up Plan, in the event of need, to ensure service is not interrupted, and to notify the appropriate personnel when the need to implement the Back Up Plan has occurred.

- **RIGHTS UNDER THE HOME & COMMUNITY BASED WAIVER PROGRAM**
  all rights and responsibilities under the Waiver program shall apply.

PARTICIPANT'S RESPONSIBILITIES

- **RESPONSIBILITY TO TREAT OTHERS WITH RESPECT, DIGNITY AND HONESTY**
  You are responsible for being honest and respectful toward the people who provide your services.

- **RESPONSIBILITY TO SHARE CRITICAL AND ACCURATE INFORMATION**
  You are responsible for letting your MFP Transition Coordinator know if you are having problems with your service or if you feel that your rights are not being respected.

  You are responsible for providing true and complete information to your MFP Transition Coordinator specific to the assessment process, transition planning, and implementation and ongoing care provided through an authorized plan of care.

  You are responsible for notifying your primary care medical provider of any health or medical changes or concerns, in a timely manner.

- **RESPONSIBILITY FOLLOW CARE PLAN AND PROGRAM RULES**
  You are responsible for following the plan of care you agreed to and the program rules governing ***Finding A Way Home*** and the

_____	_____	_____
Participant's signature	Participant's name (please print)	Date
_____	_____	_____
Legal Guardian's signature	Guardian's name (please print)	Date
_____	_____	_____
Transition Coordinator Signature	Coordinator's name (please print)	Date

If at any time you have questions call the Division of Medicaid & Medical Assistance, *Finding A Way Home* Project Director at: 800-372-2022.

Appendix Q: Customer Satisfaction Survey

Finding A Way Home
Draft Consumer Satisfaction Survey

For the following questions, please place a check mark next to the correct response. Please check only one (1) response to each question.

1. Did you use the Transition Guide developed by the project?
   □ Yes □ No

   If Yes, was it helpful? □ Yes □ No

2. Overall, how satisfied are you with your current living situation and supports?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

3. How often do you go out into the community for recreation and enjoyment?
   □ Several times a day □ Daily □ Several times a week □ Weekly
   □ At least monthly □ Less than monthly □ Not at all

   How would you rate this activity in terms of your expectations?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

4. How often do you receive visits from friends and family?
   □ Several times a day □ Daily □ Several times a week □ Weekly
   □ At least monthly □ Less than monthly □ Not at all

   How would you rate your satisfaction with the amount of visits from friends/family in terms of your expectations?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

5. How often do you communicate (telephone, e-mail, etc.) with other people aside from making appointments or arranging services?
   □ Several times a day □ Daily Several times a week □ Weekly
   □ At least monthly □ Less than monthly □Not at all

How would you rate your satisfaction with the amount of communication with other people in terms of your expectations?
□ Very Satisfied □ Satisfied □ Neutral
□ Dissatisfied □ Very Dissatisfied

6. How often are you alone?
   □ Several times a day □ Daily □ Several times a week □ Weekly
   □ At least monthly □ Less than monthly □ Not at all

   How would you rate your satisfaction with the amount of time you're alone in terms of your expectations?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

7. How often do you have contact with people in your life (other than those paid to help you) to help you figure things out and who are supportive to you?
   □ Several times a day □ Daily Several times a week □ Weekly □ At least monthly □ Less than monthly □ Not at all

   How would you rate your satisfaction with the amount of this type of support in terms of your expectations?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

8. How often do you have personal assistance and support from people who are paid or from an agency or organization that is helping you?
   □ Several times a day □ Daily □ Several times a week
   □ Weekly □At least monthly □ Less than monthly □ Not at all

   How would you rate your satisfaction with the amount of this type of support in terms of your expectations?
   □ Very Satisfied □ Satisfied □ Neutral
   □ Dissatisfied □ Very Dissatisfied

9. Are the following sufficient for your needs?

Financial resources	□ Yes, sufficient	□ No, not sufficient
Housing	□ Yes, sufficient	□ No, not sufficient
Transportation	□ Yes, sufficient	□ No, not sufficient
Making your own decisions	□ Yes, sufficient	□ No, not sufficient
Feeling safe	□ Yes, sufficient	□ No, not sufficient
Privacy	□ Yes, sufficient	□ No, not sufficient
Overall living situation	□ Yes, sufficient	□ No, not sufficient

For the areas where your supports are not sufficient, please tell us what problems you are facing and how you are managing the situation.

_____
_____
_____
_____

10. Are there other problems you are encountering that you would like to tell us about?

_____
_____
_____
_____

11. What is the best part of the way you are now living – What in your life right now makes you happy?

_____
_____
_____
_____

12. Since you moved out of the facility, have you had contact with anyone from the Finding A Way Home Project or any of the people who helped you leave the facility?

□ Yes
□ No

If Yes, who has been in contact with you?

_____
_____

Did you find the contact helpful? □Yes □No □Did not have contact

13. Would you like the Transition Coordinator or anyone who helped you leave the facility to contact you? □ Yes □No
    If Yes, who would you like to contact you?

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14. May we call or visit you to discuss this survey? □ Yes □ No

Just a few more questions: There has been much interest about individuals who have transitioned from facilities; whether they worked in the past and if any of them have returned to work or are seeking work.

Please tell us:

1. Are you now working? (Check all that apply)
   □ Yes □ Full-time □Part-time □ Temporary Volunteer
   □ I have worked since returning to the community, but am not working now.

   □ No, Retired I'm not interested at this time.

   □ I would like to explore options for working.

In the past:

2. Have you ever worked for pay?
   □ Yes □ No
   If No, have you ever worked in a non-paying (Volunteer Situation?)
   □ Yes □No

If you have worked for pay in the past, and are not working now, please tell us a little more about your previous work experience:

3. When did you stop working?
   □ Less than 3 months ago
   □ 6 months to a 1 year ago
   □ 3 to 6 months ago
   □ 1 or more years ago

4. How long did you work for your last employer?
   □ Less than 6 months ago □ 2 years to up to 5 years
   □ 6 months to less than 1 year □ 5 years or more
   □1 year to less than 2 years

5. How many hours did you typically work each week at your last job? _____/ week

6. What was your average hourly wage before taxes for your last job? Was it…
   □ Less than $7.00 an hour □ $7 – 9.99 an hour □ $10 – 12.99 an hour
   □ $16 – 19.99 an hour □ $20 – 24.99 an hour □ $13 – 15.99 an hour
   □ $25 or more an hour□ Other: $_____per_____

7. What best describes your last job?
   □ A job with competitive wages in the community which you applied for, and was not set aside for persons with a disability
   □ You were self employed.
   □ A job with competitive wages in the community which is set aside for persons with a disability – only people who have some type of disability can apply
   □ Supportive employment – Using a job coach or other individualized support to help you get or work at a job
   □ Vocational program or group supported employment
   □ Transitional employment where you are placed in a job for limited time by an Agency
   □ Sheltered workshop or enclave
   □ Other (write in) _____

8. What did having a job mean to you?
   _____
   _____

9. How much did you like your last job? Did you like it….

   □ Very much □ Not very much
   □ Somewhat □ Not at all

10. At this time, are you actively looking for a job?
    □ Yes
    □ No

11. During the next 12 months, how likely is it that you will get a job? Check only one (1).

    □ Very likely □ Not likely
    □ Somewhat likely □ Not at all likely

12. What are the barriers that keep you from working?

_____
_____
_____